DOCUMENT RESUME

ED 155 333 CE 016 158

TITLE Double Dynamics: Women's Roles in Health and Illness. A Report of a Conference Conducted by The Center for Women in Medicine, The Medical College of Pennsylvania (Philadelphia, Pennsylvania, December 7-9, 1975)

INSTITUTION Medical Coll. of Pennsylvania, Philadelphia. Center for Women in Medicine.

SPONS AGENCY Health Resources Administration (DHEW/PHS), Rockville, Md. Office of Health Resources Opportunity.

PUB DATE Dec 75

CONTRACT HRA-230-76-0073

NOTE 87p.

EDRS PRICE MF-$0.83 HC-$4.67 Plus Postage.

DESCRIPTORS *Administration; *Change Strategies; Conference Reports; Consumer Economics; Decision Making; *Females; Heads of Households; *Health Personnel; Health Programs; *Health Services; Program Effectiveness; *Program Improvement; Sex Role; Volunteers; Working Women

ABSTRACT

The conference reported here was held (1) to assist the Office of Health Resources/Health Resources Administration in developing a long-range plan and identifying strategies to improve the efficacy of women in the health system and (2) to recommend by priorities those actions which would have the most positive impact on the status of women in health. Two conference addresses, an overview of conference objectives and format, and a summary with recommendations focus on the role of women in health and illness with respect to the following: the structure and organization of the present health care system, financing policies as they relate to these issues, regulations needed to facilitate these changes, and appropriate strategies. Included in the appendix is a series of twelve mini papers which address the issue of improving the health efficacy of women in the following four major categories: as paid providers, as consumers, as extra market providers, and as decision makers. Also included are a bibliography of background materials, a list of the conference participants, a list of group members and leaders, the conference evaluation, and a list of reviewers of the conference summary and recommendations. (JH)

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ED155333

DOUBLE DYNAMICS:
WOMEN'S ROLES IN HEALTH AND ILLNESS

A Report of a Conference conducted
by The Center for Women in Medicine,
The Medical College of Pennsylvania

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

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December 7, 8, 9, 1975

Philadelphia, Pennsylvania

CE 016 158

This conference was supported by contract #HRA-230-76-0073 from the Office of Health Resources Opportunity, Health Resources Administration, Public Health Service, Department of Health, Education, and Welfare.

PREFACE

The Office of Health Resources Opportunity (OHRO) is located within the Office of the Administrator of the Health Resources Administration (HRA), Public Health Service, Department of Health, Education and Welfare. OHRO works with all Bureaus, Centers, and Offices of the HRA to complement their efforts in promoting equity in access to health careers and health services for the disadvantaged and for women. In addition, OHRO has specific programmatic responsibilities for its varied constituencies and includes the only staff within the Public Health Service devoted to a broad range of extramural programs for women and health. This Special Programs staff has an HRA-wide responsibility to implement an action plan for dealing with the complex issues of women as providers and consumers of health services.

The Conference, Double Dynamics: Women's Roles in Health and Illness, was held as a first step in assisting the OHRO/HRA in developing a long-range plan and identifying strategies to improve the efficacy of women in the health system, and to recommend by priority those actions which should be undertaken which would be most significant in their impact on the status of women in health.

The group of fifty participants of both sexes were chosen from a broad range of professional, occupational, geographic, private/public sector and minority groups to contribute their experience and expertise to OHRO in addressing its objectives.

The matrix (Page iii) for the Conference was designed in the context of the total health care system to address the issue of improving the health efficacy of women in four major categories; Women as Paid Providers; Women as Consumers; Women as Extra-Market Providers; and Women as Decision Makers. Participants were assigned to one of four groups for the entire Conference. Efforts were made to assign to each group an equitable mix of backgrounds and interests. Each of the small groups was assigned one of the four categories above to discuss from that point of view the structure and organization of the present health care system; financing policies as they relate to these issues; regulations needed that would facilitate needed changes; and strategies for research and/or action which would bring about these changes. In addition, another dimension was added by looking at each of the issues from these points of view in terms of the following: 1) accessibility of health and medical services; 2) appropriateness and acceptability of health and 3) health career opportunities (both educational and vocational).

Participants were provided in advance with resource materials consisting of mini-papers, each of which was commissioned to cover

one facet of the existing situation relating to the theme of each group as well as a number of background articles which covered a broad range of issues relating to women as consumers and providers of health care. (Appendix I, Mini-Papers: Appendix II, List of Other Resource Materials).

One major paper growing out of the Conference recommendations has been commissioned following the Conference and will be available in the Fall of 1976.

M A T R I X

DOUBLE DYNAMICS: WOMEN'S ROLES IN HEALTH AND ILLNESS

	Health System Issues			
The Efficacy of Women As:	Constraints (Positive & Negative)			Agenda for Research and/or Action
	A. Structure & Organization	B. Financing Policies & Practices	C. Regulation	
Paid Providers (Group I)				
Consumers (Group II)				
Extra Market Providers (Group III)				
Decision Makers (Group IV)				

Policy Issues as They Apply to Women
(Considered in Relation to Any of the Above Cells)

1. Accessibility of health and medical services
2. Appropriateness and acceptability of health and medical services
3. Health career opportunities (educational and vocational)

N.B. Context for Deliberation
The goals of the health system are to improve the health of the population through the development and enhancement of health efficacy.

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Health Resources Administration
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Department of Health Planning and Administration
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AGENDA

"Double Dynamics: Women's Roles in Health and Illness"
Sheraton Airport Inn, Philadelphia, PA
December 7-9, 1975

Sunday
December 7

6:00 PM Reception — Liberty Rooms A&B

7:00 PM Dinner

Welcome to Conference
Nina B. Woodside, M.D., M.P.H.
Director
Center for Women in Medicine
The Medical College of Pennsylvania

Opening Remarks
Clay Simpson, Ph.D.
Associate Administrator for Health
Resources Opportunity Programs,
Health Resources Administration

Health Efficacy - A New Paradigm
Eugenia Carpenter, M.P.P.
Assistant Research Scientist
University of Michigan

Background, Objectives and Format of Conference
Maggie Matthews, Dr.P.H.
Assistant Director for Special Programs
Office of Health Resources Opportunity

Monday
December 8

7:30 AM Breakfast — Liberty Rooms A&B

8:30 AM - 12:30 PM Group Sessions — Suites as assigned

I. Women as Paid Providers
II. Women as Consumers
III. Women as Extra-Market Providers
IV. Women as Decision Makers

Monday
December 8

12:30 PM	Luncheon	Liberty Rooms A&B
2:00 PM	Group Sessions (Continued)	Suites as assigned
6:00 PM	Reception & Dinner Status Report	Liberty Rooms A&B
8:00 PM	Group Sessions (Continued)	Suites as assigned

Tuesday
December 9

7:30 AM	Breakfast	Liberty Rooms A&B
8:30 AM	Group Wrap-up Session	Suites as assigned
10:30 AM	Group Reports Discussion and Summarization	Ballroom A
12:00 PM	Luncheon and Adjournment	Liberty Rooms A&B

OPENING REMARKS

Clay Simpson, Ph.D.
Associate Administrator for
Health Resources Opportunity Programs

I speak for Dr. Kenneth Endicott, the Administrator for the Health Resources Administration and the Office of Health Resources Opportunity as I welcome you to this our initial effort that hopefully will lead to an Action Plan for a meaningful women's program. I should like to suggest that for the past decade we have been missing the reverse side of a very important coin. It is my contention that with all the emphasis for the last ten years on the humane side of the liberation of people, black people, Chicano, native Americans and women we have heard too little about the terrible waste of human potential and abilities should we fail to provide equal opportunity for all Americans. There are obviously good, sufficient and humane reasons that people should be free to attain their optimal goals in life. Certainly, we all subscribe to those. But, we must not fail to recognize the loss to the world of ideas and of science, economics, government, business, the professions and the arts that result from denying people entry into those areas for extraneous considerations as race, sex, national origin, etc. In short, if we are ready to pursue excellence in health care we cannot do it without every bit of brain power we can muster.

The mission that brings us together this evening, then, is not so much a function of an idealistic crusade for women's liberation as it is to improve our health care system by making sure we are recruiting, training, assigning and using the brain power that women among other groups can bring to the field. We can take as our point of departure, the words of a signed editorial in a recent issue of Science Magazine written by Betty Vetter, Executive Director of the Scientific Manpower Commission, and I quote, "It seems apparent that if women and members of minority groups are to be encouraged to prepare themselves for careers in the sciences, the scientific community as well as the employers of scientists in all sectors must offer them the same opportunities as white men to find suitable employment, to advance according to their abilities and to be paid commensurately for their services." In these few words, Ms. Vetter speaks to a part of our mission here.

Tomorrow and Tuesday you will be addressing your best talents to the problems women face as they interface with the health system as students, providers and procurers of services. We need to hear what you think would be realistic, attainable goals for health programs in relation to women. You will, in accordance with the title of

this conference, wish to look searchingly at a wide range of problems facing women in the health care field. You should be concerned not only with access to health careers, but also with the position of women in relation to problems of health care. We in the Office of Health Resources Opportunity ask your help not because we think we have been doing a bad job but because we think that with your help we can do a still better job. You were chosen for this task because you are capable, intelligent, imaginative people who we think have at least some of the answers we need. In this room are people who have been addressing problems of women in health care for a long time. We need your ideas on program priorities. We want you to address such nuts and bolts questions as--how long will these programs take, and what objectives will they satisfy.

For our part, let me assure you that the Office of Health Resources Opportunity is anxiously awaiting your recommendations. You should know that this Conference will be one in a continuing series of conferences bringing together knowledgeable and sophisticated people speaking for the various groups that make OHRO's primary constituency. We have had highly successful conferences of Black and Asian health related organizations. Conferences are in the works with Spanish-surnamed groups and we have begun to meet with native American organizations to receive their recommendations. Out of this matter of input and information will come a cohesive program which will be best suited to our agenda in the Office of Health Resources Opportunity and the Health Resources Administration, and I believe our agenda is wholly coherent with yours.

We want to make sure that we do not lose professional and paraprofessional talents in the health care fields to such unworthy considerations as prejudice or discrimination against anyone for the reasons of sex, race or national origin, and that all Americans will have the opportunity to gain access to available health resources. We think in terms of a wide spectrum of people from the Black innercity child to the Appalachian poor white to the woman in Philadelphia's Main Line suburbs who has for vague reasons been turned down for health professions or job training. You speak for women in health care and we want to hear what you have to say loud and clear. We want to hear it even if it should strike some ears as unwelcomed, because only in that way can we hope to assure ourselves that our priorities reflect your needs. Again, we thank you for your time and for the contribution you are sure to make.

HEALTH EFFICACY - A NEW PARADIGM

Eugenia Carpenter, M.P.P
Assistant Research Scientist
Department of Health Planning and Administration
School of Public Health
University of Michigan

I want to explore with you tonight an idea that, I must tell you frankly, is still in its early stages in my mind. Interestingly enough, the genesis of this idea came to me at a conference this year, which shows you that conferences need not necessarily be unproductive. During the conference there came to be some rather heated discussion about the nature of and need for data in the area of health services for the disadvantaged, including women. There seemed to be a division in the group between those who thought these were purely technical issues and those who thought there were significant political overtones. The more academically oriented, perhaps, felt that there was a lot of unnecessary rhetoric and politicizing which was inappropriate.

As I sat there feeling somewhat frustrated by the discussion, I began to think of the very strong interface between health policy, the health system and politics. It occurred to me that there is a concept in political science that might be transferred to the health system and possibly developed as a new way of looking at health behavior which could have implications for restructuring our health system. This is what I have called health efficacy, because I borrowed the term from the concept of political efficacy in political science. Political behaviorists have developed this concept over the last couple of decades out of the electoral research that has gone on in a number of academic institutions, notably, my own. Political efficacy refers to some measure of an individual's feeling of confidence in, or belief in, his or her ability to participate in an effective way in some kind of political activity.[1] It seemed to me that when we are talking about the way people access and use care, we are really concerned about the feeling they have as to whether they can maneuver in the health system in an effective way.

There is comparability here, too, between the political and health arenas because we find in the studies of health behavior that problems of accessing of care seem to be associated with socioeconomic indicators, education, income, occupation, just as political scientists have found the connection between status indicators and political participation. It seemed to me that this way of thinking about the health care system was worthy of exploration. We need to

try to explore the black box phenomenon through which the socio-economic measures are translated into observed health behavior.

I think, too, in this conference in which we are concerned with change and how to effect the kinds of change that we may feel desirable, that there is a relationship between the concept of efficacy and theories of social change. Goals of social change have been described by James Coleman as an increase in control over the conditions of existence, or, alternatively, as an expansion of resources which, in turn, make possible a wider range of choice. [2] That description sounds like the objectives we have been looking for in terms of our efforts to improve women's ability to maneuver in the health system, both as providers and consumers, so as to make possible a wider range of choice. As we discuss the various issues in the course of the next two days, I think we will see that we are talking about a wider range of choice for all of us, not just women, but everyone.

Theories of change tend to focus in one direction or the other. Either they focus on changes within the individual--that is, a sort of "hearts and minds of men and women" approach--or on changes in the social conditions in which individuals find themselves. You will find that my bias is more toward the social structure approach, because I feel that that is where we have the greatest opportunity of making changes. As an operational concept then, health efficacy seeks to present a kind of fresh perspective on health behavior and in doing so, move from the focus on the psychological determinants of individual behavior to a more macro view which looks at the interaction of social forces and institutional arrangements which set the systemic constraints within which individuals operate. This kind of approach suggests that we should direct our public policy in the health area toward making institutions more responsive as a means of enhancing individual effectiveness in the health system.

What are some policy implications of a health efficacy concept? First we might say that it could lead to the demedicalization of health care, that is to say, to the view that health is produced by people not by providers, institutional or individual. If you like, we could make an economic analogy and say that the individual or the family unit is the firm and it is using inputs of capital and labor in a production process that includes activities that promote and enhance wellness. This concept forces us to focus on the total set of inputs that are required for the production process, not just medical care. So we are talking about nutrition and housing and the environment. We are talking about the kinds of things that women are involved in day to day in their traditional family roles. The individual, then, becomes a kind of entrepreneur, and he or she needs knowledge, know-how, so that he/she can become a good decision maker who will learn to

make the right kinds of decisions. Certainly we will be focusing on this aspect of women's roles during this Conference, women's traditional family role of combining inputs to the health production process. This approach restores independence and dignity to the individual by focusing on the primacy of health promotion.

Other implications for new directions for research in health behavior and its application to health delivery and health education that may flow from the concept of health efficacy include such things as the emphasis on environment and life style factors in health. This you will recall is the thrust of the La Londe Report from the Canadian Ministry of Health, which is a most interesting and seminal report on new directions in health. [3] This approach reflects essentially what Victor Fuchs is saying in his latest book, that health is only marginally affected by that part of the system which we call medical care. [4] The idea of environment and life style can, I think, be a somewhat radical one. Dan Beauchamp has noted that if we view this emphasis on environment and life style as focusing not on individual behavior and its determinants, but upon the structural determinants of health status outcomes, we can move to a totally different approach to health. [5]

I think too, that the health efficacy approach can lead us from elitist notions of the aristocracy of health professionals to a democratic participatory model of health. Unfortunately, even health educators seem to fall into the pattern of passing received wisdom, so that, for example, one monograph on research in health behavior emphasizes the need to "determine principles by which individuals, especially those in lower socioeconomic groups, can be persuaded to alter their health opinions, attitudes and behavior." [6] We all recognize that experience with health education efforts up to now has indicated that individual behavior is a rather intractable variable. Moreover, to continue to focus on individual behavior alone, particularly in the context of an elite professional core instilling its wisdom into a dependent clientele is to fall in what Elliot Friedson has called the trap of "common sense individualism." This is the fallacy by which we assume that outcomes are largely determined by individual attitudes, reasons, motives and capacities. [7] I would say that we have to look at the interface between individual behavior and the health system and this is what we will be attempting to do in the way we have structured this Conference.

What else is transferable from the political theory that can help us in developing this new paradigm? First, people have independent rights and responsibilities for their health and they need to be given the opportunity to exercise them in decision making in the health system. But we must also recognize the congruence between present attitudes of hopelessness, disaffection, anomie, vis-a-vis the health care system and the real barriers to the effective

participation within it of large numbers of citizens. I think in political science we may similarly overlook the fact that people's attitudes of indifference and disaffection with the political system reflect reality: attitudes reflect deficiencies in the system, not merely the fact that the individual is uneducated or uninformed. There is an interaction between the system and the attitude that we have to recognize in health systems as well as in political systems. In terms of moving ahead, we need to stress understanding of how to maneuver in the system. We should stress not how to achieve scientific technological knowledge so as to understand or practice the healing arts, but rather knowledge of how the present system works, as a first step in diagnosing what is wrong with the system, so as to prescribe what needs to be changed.

If it can be developed as an operational paradigm, health efficacy promises to provide some understanding of how participatory mechanisms link the individual and the health care delivery system. In particular, exploration of the health efficacy concept might shed more light on discretionary health behavior than health status indexes, which seem to have greater relevance to need-oriented, sickness-related utilization of medical care services. [8] Thus, if national health policy is to shift its emphasis to health promotion, we need to understand and develop measurements of what Henrik Blum has called the capacity to participate in the promotion of health and the utilization of health care. [9]

Finally, most women now play a double role in health promotion and health care utilization for their families by providing extra-market health services for their families as well as serving as the interface with the formal health care delivery system for the family unit. The concept of health efficacy may help us better understand how women now carry out this dual function. I would also hope that we might gain insight into needed changes in social systems including health care delivery so as to enhance the capacity of women and men to participate in the promotion of health.

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BACKGROUND, OBJECTIVES, AND FORMAT OF THE CONFERENCE

Maggie Matthews, Dr.P.H.
Assistant Director for Special Programs
Office of Health Resources Opportunity

Along with Dr. Simpson, I want to extend a warm welcome to all of you and tell you that I very much look forward to your participation in our discussions of the next two days.

Before I speak briefly of objectives and format, I thought you might like to know a little about the wide range of disciplines, professions, fields, and interests represented here since this may not be immediately evident from reading the list of names and addresses which we gave you. Although I am sure I have missed some of them, here are a few specialties I identified: medicine (particularly psychiatry, pediatrics, and preventive medicine), nursing, allied health, dentistry, public health, counseling and guidance, social work, health education, law, sociology, psychology, political science, history, anthropology, epidemiology, statistics, economics, nutrition, health administration, health planning, health policy, health manpower, labor and industrial relations, women's studies and women's health. We have health services providers, administrators, educators, researchers, volunteers in the private sector, and consumers. We have representatives of federal, state, and local governments, and professional and voluntary associations.

Some of us, of course, have also had prior experience or are concomitantly engaged in several of these fields or activities. In addition, many of us at some time in our lives have known first hand the realities of membership in a group disadvantaged in regard to achieving all the benefits of, and full participation in, this society; thus we have a special sensitivity for particular health issues relevant to those groups.

Now, there are probably a lot of other things that I do not know about you, but I hope this recital may illustrate the breadth of the group. Since our intention was to search for people from very diverse backgrounds and try to avoid tunnel vision in singular and limited areas of expertise, I am pleased to say that your acceptance has indeed provided us with this wide range. Your seemingly arbitrary assignment to the specific working groups was also intended to bring a wide range of knowledge to each. In other words, we did not intend that only people familiar with a given topic would be those who were participating in discussing that subject.

We started on the assumption that all of you are excellent thinkers, and we want, in essence, brainstorming sessions or mini-think-tanks. We assume that we are starting from some common bases of understanding, that at this Conference we will not have to reinvent the wheel, and that we can take as given many of the conditions of our society, particularly the socialization process for the men and women in it. I really want to stress that point since so many of us have attended conferences dealing with the problems or status of women in which the bulk of the time was spent discussing facts such as a pink blanket placed on a baby immediately sets in motion a very lengthy process of socialization, with a specific set of role behaviors ascribed from that point on because labeled female. We would hope that we do not have to reiterate very many of those basic points, that we can begin at a certain level of sophistication and go from there, because we are on a short time frame and have a great deal to talk about.

Finally, in terms of background, I want to note that Eugenia Carpenter has set the tone and philosophy of the Conference. We have been considering the concept of health efficacy with her for a long time, but she is, of course, its originator. Anything we can do to help her define it further, as well as broaden our understanding of its application to women, may well be one of the most fruitful outcomes of this Conference. In addition, let me say that we do, of course, recognize the complexity and magnitude of the issues before us; yet within that context we must focus down on specific issues as they affect the efficacy of women in their roles vis-a-vis the health system. Now, I use efficacy here as a synonym for effectiveness, which is not quite the same as its use in the developing concept of health efficacy. Since total system change appears immutable at present, we are talking about what we might call purposive incrementalism, but we are not talking about disjointed incrementalism, I hope. In other words, we have to make an attempt within the context of this complexity to zero in on conditions that we can deal with realistically, as well as those which will yield to the kinds of strategies that I hope we will be generating.

We know that the major goal of our efforts is improved health status of the population, and we do not wish to forget that. We know that women are the majority of the providers of health services, both in paid employment and in their extra-market services. We know, in general, that they are the bulk of the consumers of health services and the major determinants of how and when to access the system for themselves, their children, other family members; but first we need to be able to document what they actually do contribute. Document, I say, because a great deal of this we know intuitively, but we do not have hard data. Secondly, we must ask how women can be more effective in their roles; that is, what do they need to

do to perform their jobs better, whether they are paid workers or are providing services and support systems in their homes. A third consideration would then be, what can the federal government do to imporve the health efficacy of women?

The two specific objectives of this Conference are 1) to assist the Office of Health Resources Opportunity/HRA in developing a long-range plan and identifying strategies to improve the efficacy of women in the health system, and 2) to recommend by priority those actions which should be undertaken which would be most significant in their impact on the status of women in health. We, in our Office, are taking a positive stand, and thus the Conference title, "Double Dynamics." We know about the problems, we know about discrimination, and you do, too. We are ready now to hear how making improvements in the status of women in health will better the entire health system and improve that system for the benefit of all people, not just for women.

The format we have chosen is a matrix within a systems framework (Page iii). We recognize that the four groups in the vertical column are not discrete--there are major overlaps. For example, when we get to the third group, extra-market providers, we are also talking about consumers. The fourth group, decision-makers, refers to decisions made by paid providers in Group I, as well as those by extra-market providers particularly, but also by consumers. These considerable overlaps provide another reason why participant assignments to the groups were based on our feeling that we wanted wide scope in each group, assuring contribution from a number of disciplines.

We commissioned short papers for each of three cells for each group, and all of you have received the whole set of twelve. I want to stress that these are intended only as examples of possible topics for discussion. In no way are they intended to be definitive, scholarly papers on each topic. We would like to have you generate other kinds of thoughts and ideas to fit in the various cells of the matrix for your particular groups. Thus we hope the papers will serve primarily to spark discussion. Each facilitator is the author of that group's three papers, so each group will have the best resource person to discuss each particular paper as a start-off. We, therefore, have a very bare beginning for twelve of the cells in the matrix. The cells in the righthand column, labeled Agenda for Research and/or Action, are blank, and we hope to generate this agenda during the Conference.

We have tried to include a third dimension by raising policy issues at the bottom of the matrix: considerations of accessibility, appropriateness, acceptibility, and opportunity. Whenever you can find that these policy issues relate to your discussion topics

from the two-dimensional matrix above, then they should be included. There is little else I can say now to elucidate this any further, but each group facilitator in the morning will be glad to deal with the matrix more specifically as the group questions what we are attempting with this structured format. I would suggest that each of you particularly read the three papers for your assigned group, but we have given you all twelve so that you can see the entire gamut. Four of us who are not assigned to a particular group will take turns stopping in for two hours in each group so that each of us will touch on all the groups at some point before the end. I want to say again that I think the format is very complex; overall it presents a gigantic topic and we have only one and a half days to deal with it. If, finally, your recommendations were to indicate that we cannot deal with it all in so short a time, but we should have other conferences on the specific issues, then fine, we want to hear you say that too. I think we are really trying something that is a different approach from any that I have seen previously. But, by structuring the Conference this way, we did hope we would carry out an exercise which would give us some very specific outcomes instead of simply generating a great deal of anecdotal, interesting conversation.

Now I will open the floor to questions and hope that we can provide answers which will clarify our intent as well as the Conference objectives and format.

CONFERENCE SUMMARY AND RECOMMENDATIONS

Double Dynamics:
Women Using and Providing Health Services

Janet A. Strauss, M.P.H.

INTRODUCTION

Conference Format - Working Groups and Reports

Women's participation in the health and medical care system has been identified in four modes: paid provision of care and services; use of health and medical services; extra-market, unpaid, provision of care and services; and decision-making. For this conference, working groups were formed to analyze and discuss issues, desired changes, and strategies for accomplishing change in each of these role areas in relation to a health system matrix (Page iii). Invited participants were assigned to the four groups and facilitators prepared mini-papers, included in Appendix I of this report, to be used as stimuli for discussion.

Group working sessions, over a period of one and a half days, addressed the enormous range of problems, possible solutions, and alternative strategies available. Two summary sessions, at the end of the first day and after the second morning's session, exposed the several groups' directions and thinking to the participants as a whole. Reactions and further questions raised in those sessions were thus available for use in the reports prepared by the groups' recorders.

Although it was difficult to consider the positives of women's situations vis-a-vis the health and medical care system without dwelling on negatives - past and present injustices and inequities - recommendations for OHRO action and catalytic effort have been stated in the group reports in the double dynamics context, stressing ways in which existing and potential knowledge, attitudes, and skills may be applied and activated, and ways in which OHRO may be supportive and directive.

The work of the four groups is synthesized and summarized on the following pages, first in an overview, followed by assumptions made, then giving the specific issues and desired changes, and finally the recommendations.

Overview of the Conference and Action Theme - Double Dynamics

Of those who use and provide health services and medical care in

the United States, the great majority are women. This fact, often with such figures as that two-thirds of physician visits annually are made by women and that women comprise over three-fourths of the health and medical care labor force, is noted in virtually every statement dealing with women's roles in health and illness. It was the basic "given" for the working sessions of the OHRO conference reported here and was stressed as carrying potency and potential for change. Yet this given goes almost totally ignored, even unrecognized, by those in charge of the health and medical care system.

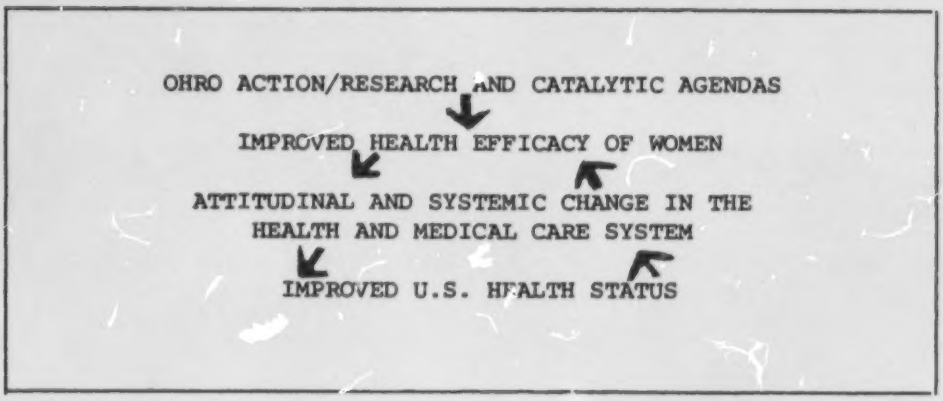
Effectiveness of that system is diminished because the majority of women lack opportunities and also incentives to know and understand fully the health and illness care available to them, and to use fully their knowledge, attitudes, and skills in provision of care and in the making of decisions about form and delivery of that care. Remedies for this underutilization of women's experience and expertise are not sought by the few who establish policy and make decisions for and within the system.

Despite their preponderance in the health care work force, women are noticeably absent from positions of leadership in organizing, providing, administering, and planning health services. This disparity between numbers and influence was also basic to the conferees' deliberations, decisions, and recommendations. To find ways to release and utilize the potential harbored by the majority of both consumers and providers, and so motivate and create opportunities as well as imperatives for participation and leadership were implicit goals of the conference.

OHRO, as the unit within HEW's Health Resources Administration responsible for government attention to minority and women's concerns in health matters, shares these goals. OHRO also has both the same potential and responsibility as ascribed above to women. This conference brought together talent and ideas for creating essential opportunities, through OHRO directly and with OHRO serving as catalytic agent, to precipitate change that can result in improved health status of the American population.

Implementation of conference recommendations -- for developing opportunities, incentives, demonstrations, and research projects, as well as catalyzing policy formulation, legislation, and regulation -- can effect real and substantial change. If the desired and recommended kinds of change do indeed occur, the health and medical care system can become less technology-intensive, more accessible, and more humane. The system can evolve toward health protection and promotion, away from crisis-oriented, after-the-fact therapeutic care, with help from such efforts as OHRO's investment in activating these recommendations.

The double dynamics conference was predicated on long-range assumptions which may be illustrated as follows:


OHRO ACTION/RESEARCH AND CATALYTIC AGENDAS
IMPROVED HEALTH EFFICACY OF WOMEN
ATTITUDINAL AND SYSTEMIC CHANGE IN THE HEALTH AND MEDICAL CARE SYSTEM
IMPROVED U.S. HEALTH STATUS

The pivotal point in achievement of long-range conference outcomes, as shown in the diagram above, is enhancement of women's health efficacy. In one sense this means women's power to produce effects and results in health and illness situations; alternatively, efficacy can mean women's confidence in their own ability to produce such effects or results.

For efficacy to exist in either sense, every possible aspect of women's roles must be located and explored. Opportunities must be created to:

- enhance the knowledge, attitudes, and skills women already have in health and illness care;
- gain recognition for those attributes; and
- put them to effective uses.

In short, there must be opportunities for women to know what they use, as consumers, and to use what they know, as providers and decision-makers. A climate must be established for double dynamics.

ASSUMPTIONS BY ALL WORKING GROUPS

In each group certain conditions and characteristics were assumed

so that women's health consumer and provider roles and participation could be portrayed as realistically as possible and the positives identified fully. Cutting across all four groups were the following assumptions about women's place in society and in the health and medical care system.

1. Early childhood socialization of both males and females, which assigns and stereotypes sex-differentiated roles, will not be radically altered in the near future except in scattered situations.

2. Education and counseling patterns continue to reinforce family-oriented socialization of women, while modern mass media provide further reinforcement.

3. Basic values operating in our health and medical care system are skewed away from health support and promotion, and illness prevention; instead they favor intervention after disease and illness have occurred, using services which are highly professionalized and technological.

4. Most women involved with the health and medical care system are "locked into" categories and levels of consumer roles and provider activity; they are "locked out" of decision-making roles. More specifically: a) women do not have the information and opportunities requisite for functioning as participatory consumers; b) as providers they are unpaid (extra-market), and/or remunerated at low rates for lower level professional or paraprofessional jobs, and/or overwhelmed by numbers of male colleagues in upper-level professional positions; c) there is no established process for upward mobility or for provision of mid-career opportunities; and d) women are not looked to routinely in terms of policy/decision making, nor other leadership functions.

5. Since instant change in stereotyped family roles is neither likely nor feasible, women will need to support dual roles, and/or employ alternates to perform domestic duties, for some time to come. Many women will continue to function solely as homemakers and mothers; but increasingly both choice and economic necessity will pull women into the labor force. At all levels, arranging for child care will present the greatest challenge and problems.

6. Extra-market services provided by women represent the most basic pre-primary, primary, and post-institutional care provided, but go unrecognized and unrewarded in the health and medical care system.

7. As consumers, women engage in health behavior and make decisions about needs and care on the basis of socially-filtered information; basic information about health system policy and regulation reaches most women indirectly if at all.

8. Stereotyping and tradition make it unrealistic to expect either immediate or massive change in any of the above areas. At both individual/attitudinal and institutional/systemic levels, incrementalism will prevail despite isolated spurts of more radical change.

ISSUES AND DESIRED CHANGES

Assuming the preceding sets of circumstances, the four conference groups set out issues to be dealt with and changes to be initiated. Again, a number of these cut across the four role areas, while some were more specific to one area or another. Both across-the-board (1. through 5.) and special (6. through 9.) issues and problems are summarized as follows:

1. Socialization. This issue must be addressed at a number of levels in a variety of ways. In general, women's self-images and society's images of them must be altered from ones of "double jeopardy" to ones of "double dynamics." For example, family life needs to be restructured to coincide with the restructuring of the world of work which is now underway. While child bearing is biologically women's role, child rearing must be recognized as a family responsibility, not solely a female responsibility; counseling and other educational services must be reoriented to relate to equitable opportunities for women; and sex-stereotyping in health careers must be remedied.

2. Demedicalization of the Health and Medical Care System. Apart from issues relating specifically to women's status in health consumer and provider roles, the nature of the system that deals with health and illness in this country is the most crucial matter at issue. No one seems to know, or to have given sufficient thought to how to protect, support and promote health as a common good. Available resources are devoted to treating illness, and to desultory efforts to achieve disease prevention. Our "national health policy" supports research and vast expenditures that are disease-related, while discounting our less-than-admirable national health status data. Large industrial-like medical center and hospital complexes offer services at staggering cost, with minimal attention to personalized needs, wishes, or satisfactions.

The chief source of individualized care, when it is provided, is within the family. Women as family members are the providers, as well as the determiners of consumer patterns. Ways must be found to translate and use what women know about caring to situations both within and external to the medical care marketplace, and to support and compensate women providers adequately.

These several changes must be initiated and must take place at both individual/attitudinal and institutional/systemic levels. Ways to achieve such change must be sought more vigorously.

3. Levels and Categories of Activity. As is emphasized over and over, women working in the health and medical care system form all but the elitist professional tip of the health labor force pyramid. Assuming that patients and potential patients (with women in the majority) form the foundation and lower strata of that structure, the lower status and lower paid women workers are those most closely and constantly in touch with patients. They are therefore knowledgeable about patients and their families as people, well or ill, even if not educated in the intricacies and complexities of disease and illness.

The need resulting from this circumstance is for recognition of these women's special knowledge, their conditioned attitudes, and their potential for promoting humane and personalized care in an increasingly technological health system. Their latent ability to contribute is analagous to that of the extra-market providers; indeed they are in many cases the same women, in dual roles.

At the higher professional levels of health and medical activity, women are in the minority. Therefore, to the extent that women in leadership roles now give voice to the particular health care needs of women, that voice is muted. Opportunities must be provided for realization of their leadership potential in this area as well as throughout the entire health system.

4. Dual Roles. Given the assumption, stated earlier, that women who work outside the home must function in dual roles for some time to come, it is essential that support systems be established to guarantee resources for child care, care of ill or handicapped family members, and adequate recognition and compensation for services performed, at least until that future time when resocialization will have been achieved.

5. Paid Providers. Special issues and considerations pertaining to women employed as providers of health and illness services include lack of equal opportunity and/or equitable treatment in a number of areas:

a) Licensure regulations impede the full realization of the potential of women health care providers who can serve as alternates or complements to physicians; e.g., nurse midwives, pediatric nurse practitioners, etc. Licensure also presents a barrier to career mobility. These inequities must be rectified.

b) Insurance for hospital and medical care, for disability, for

income maintenance during pregnancy and post-partum recovery, is not equitably available to employed women. Changes in regulations governing insurance and in insurance benefits, are needed.

c) Third party payments are frequently not allowed for health services provided by midwives, nurse practitioners, and other women providers. One consequence is disinclination on the part of women to enter these fields, thus hampering development of broadened health care roles and opportunities for women. Here again, changes in insurance regulations are required.

d) Women are not recruited and appointed in meaningful numbers to advisory and policy-making boards. Particularly, lay women with experiential knowledge and orientations have little opportunity to participate in deliberations and decisions about health and illness care. This area needs concerted attention.

e) Women employed in low status positions in health care organizations have minimal opportunity for upward mobility. Mid-career opportunities for retraining and employment are difficult for all but a few to locate at all occupational levels. These phenomena appear to be related to the lower social class status ascribed to women in general and are therefore discriminatory. Ways must be devised for handling these deficiencies in the system, including enhancement of job satisfaction at the lower levels of activity.

f) Equal pay for equal responsibility and work is not the rule among higher status professionals. This must be corrected.

g) Special financial supports must be established to compensate women for performing in dual roles.

h) General living arrangements, for shopping, service availability, and the like, must be given special attention for the benefit of working women.

i) Encompassing all of the above is the glaring need for society in general to become sensitized to the implications of women's situations as the majority of the health and medical care labor force. Recognition is basic, fair compensation is mandatory, and opportunity for both is essential.

6. Extra-Market Providers. Women extra-market providers supply large quantities of health promotion, health maintenance, and health education services for children, husbands, and the aged. They are also providing more and more services for themselves -- i.e., for women, by women -- outside the structured marketplace. Much of this care precedes receipt of services usually termed "primary"

and much of it, particularly for the disabled and aged, follows periods of institutional care. Therefore attention to extra-market providers is called for, to enhance their roles and/or relieve them of intolerable burdens.

Most of the informal, extra-market care is based in the home, so that the unpaid women providers are home-bound and restricted in their opportunities for outside employment and activities. Their responsibilities are often tiring and unending; and their rewards, particularly in caring for persons with chronic disabilities, are few. Community and professional support for those often thankless roles is rare. Alternatives to "free" home-based (and to institutionally-based) services and modes of care need to be considered, to relieve informal providers of the burdens of being home-bound and unpaid for their services. Women need to take concerted action to establish and develop alternative patterns for provision of high quality pre-primary and post-institutional care.

Despite the burdens imposed on women unpaid providers, there are many positive aspects of their functioning in extra-market roles. They have already accumulated, and are continually adding to, reservoirs of knowledge, attitudes, and skills relevant to health promotion and illness care for children, the aged, and themselves.

Currently, health and medical care decision-makers take little responsibility for improving informally-provided services, for the health of the unpaid providers, or for learning from experienced extra-market providers. Informal health maintenance services are not facilitated by the system and receive no resource support. Effective interactions between individual extra-market providers and health and illness care systems should be consciously promoted. And all possible encouragement must be given to use of extra-market knowledge, attitudes, and skills in development of <u>health</u> services and systems, as distinct from existing medical care services and systems.

To orient the health and medical care system to emphasize attitudes and activities which can maintain and promote physical and mental health and well-being, and to redirect the allocation of resources to the primary and pre-primary levels, action and research must occur in a variety of locations, including the home, other places where informal providers interact with medical and paramedical personnel, and in self-help centers established by women for women.

7. <u>Consumers</u>. In the processes of seeking, finding, and utilizing services available for themselves and their families, women experience frustration, discrimination, and extreme dependency. Socialized

as they, and others, are to considering the female to be "unhealthy," "neurotic," "weak," and the like, it is small wonder that women are seriously disadvantaged as consumers in a world where the sought-after providers are predominantly male.

Most basic to women's consumer concerns and difficulties are the constellation of problems that cluster around fertility and its consequences. Ways in which to manage fertility are intertwined with conditions viewed as "sickness," which carry overtones of guilt. Thus emotional, mental, and physical health and illness all relate to fertility and reproduction. Components of the fertility problem include: a) fertility control through contraception, abortion, and sterilization; b) pregnancy and delivery; c) infant care in the first year; and d) medical care for fetal loss. Management of all of these phases involves much that is not decisively identified as being either sick or well.

As consumers, women need to be educated about and to develop assurance and confidence in the professional ability of health practitioners other than physicians, such as nurse practitioners and physician assistants, and to seek out and utilize such providers.

Women's socioeconomic, racial, and ethnic orientations affect their consumer role significantly. The further problem of women's economic weakness vis-a-vis the marketplace also inhibits their functioning as consumers. In turn all of these problems relate back to the socialization and dual role aspects of women's health efficacy, so that consumer problems cannot be solved before or apart from them.

8. Decision-Making. The large numbers of women sub-professionals and paraprofessionals, many of them from minority population groups, and the even larger numbers of women consumers of health and medical services, have little if any input to the planning, organization, and administration of the system. This situation must be acknowledged openly and opportunities created for women -- as paid providers, unpaid providers, and consumers -- to contribute meaningfully to policy and decision-making and to be equitably compensated for those contributions, as well as for work they perform in specific job categories.

Women who do participate in decision-making are in almost all instances outnumbered by men, which hampers efforts they may make to present the female perspective. There is need for: a) promoting educational programs that will prepare women consumers and providers to function more effectively as decision-makers; b) enrolling more women in educational programs for executive-level health and medical personnel; c) promoting and providing support systems for women who do participate in activities such as planning, organizing, and

administering that involve decision-making; and d) instituting, expanding, and safeguarding measures designed to promote leadership roles for women.

9. Self-Motivation and Initiative. A double dynamics approach can be activated if women continue to take substantial initiative themselves and are motivated to correct existing inequities. Women possess vast untapped strengths, but their initiatives to implement health system changes have historically been blocked. With female network support, women can be instrumental in devising positive incentives to upgrade their capabilities and competence, but it is critical that opportunity and initial push be provided by government and private sector agencies. Ways to develop these are set out in the conference recommendations. Then, women themselves must take it from there.

RECOMMENDATIONS TO OHRO

Format - OHRO Agendas

With two exceptions, the conference recommendations of the individual working groups to the sponsoring agency, OHRO, are offered in two sets -- one for OHRO's action/research agenda, comprising approaches OHRO itself can and should fund and undertake directly, and the second for OHRO's catalytic agenda, calling for stimulation of supportive and cooperative undertakings involving other governmental units and private agencies.

The action/research recommendations are intended to be implemented directly through OHRO initiative and effort. Their implementation can be the focus of a national strategy to enhance the health efficacy of women by engaging them in dynamic approaches to improving health and medical care for the American people. Implementation of the catalytic effort recommended for OHRO can impact directly and significantly on policy formulation, legislation, and regulation in the several sectors of the health and medical care system.

The bulk of the recommendations in this summary have been categorized according to the titles of the conference's four working groups, and, to the extent possible, placed in priority order of both urgency and feasibility for implementation.

The two exceptions noted at the outset appear as overall high priority recommendations below. It should be noted that they have the potential to include many of the subsequent specific group recommendations.

The first was generated by more than one of the working groups and was deemed to be the top priority recommendation. It is of the greatest potential significance since it presents a national, visible effort for women and health, as well as a structural mechanism for an encompassing thrust in action, research, and catalytic spheres, instituted by OHRO but involving a wide range of public and private sector individuals and organizations. The second recommendation addresses establishing a base from which consumers can become more informed and thus better decision-makers as they accept greater responsibility for their own health and health care.

A. OVERALL MAJOR RECOMMENDATIONS

1. OHRO should fund and develop at least six national centers to serve as catalysts and to generate and administer research and action projects related to women and health.

    a. These centers should link academic, provider, volunteer, and community groups into effective mechanisms for change.

b. The characteristics for each center should depend upon the participants and their particular interests; no two centers should have identical goals.

c. Contract awards should not be limited to academic institutions.

d. These centers should be established on a gradual basis; two funded with program support and coverage in 1977 with four additional centers being added in 1978.

e. The cost of a center during its first year of operation should be estimated at approximately a quarter of a million dollars.

f. Ideally, grants or contracts should be for a three year planning and implementation phase with renewal awards extended to five year periods of time.

g. Budgetary expansion should result from project implementation.

Since precedents for this form of programmatic implementation exist, the formulation of national centers should be acceptable within DHEW.

Some possible activities of the Centers include: a study of role contrasts and economic impacts; expanded studies of career histories of women in health professions; an analysis of the implementation of affirmative action programs by educational and governmental institutions; a cross cultural analysis of women in health careers; an analysis of high school guidance counseling in health careers and demonstration projects in early counseling of school girls; advanced management programs for female health executives; training for women serving on health planning and regulatory boards and in community health projects; counseling for mature women; and fellowship programs for a) credentialed health professionals who have been inactive and require refresher courses, retraining, or redirection, b) health professions students, and c) for community volunteer health workers. Special emphasis should be placed on outreach to, and programs to meet the needs of, minority women in all programs of the centers.

2. OHRO, in conjunction with other elements of the Public Health Service, should immediately undertake establishment of a multifaceted consumer health education program to reach consumer groups with various demographic characteristics (sex, age, race/ethnicity, socioeconomic status, etc.). The first target group should consist of teenage women and those in the early reproductive years.

a. The program's objectives should be:

1) to identify, review, disseminate, and use as teaching materials existing consumer oriented health education information and to develop new materials.

2) to develop and demonstrate varied consumer oriented health education models for identifiable target populations.

b. The proposed project should include, but not be limited to:

1) selection of those who represent consumer groups as well as individual consumers to participate in program design.

2) a review and selection of existing materials suitable for the media and for training consumers.

3) development of content of new educational materials.

4) examination of the array of existing successful educational programs in health clinics and centers (both their structure and programs).

5) development of models which can be adopted, through HRA assistance, by other neighborhood health centers.

6) development of educational materials to inform women about physician substitutes, their functions, and abilities, and how to seek out these practitioners rather than physicians, for certain kinds and levels of care.

7) development of educational materials concerning occupational health and safety regulations so that working women will understand resources available through places of employment.

8) development of educational materials that will encourage women toward better self-images of physical and mental health and strength.

9) development of methodologies for utilization of educational materials.

10) demonstration projects employing the materials and models.

11) evaluation through longitudinal studies of the results achieved by the educational effort.

B. RECOMMENDATIONS CONCERNING PAID PROVIDERS *

OHRO Action/Research

1. OHRO should immediately undertake an effort to identify existing and potential allies of women who work at any and all levels in the health and medical care system. These individuals and groups should be apprised of OHRO's program and should be invited to participate at both general and specific levels of planning, research, demonstration, and other activity, to work with women and in other modes toward constructive change in the health and medical care system.

2. OHRO should within the next year sponsor a conference charged to develop methodology for establishing a network system for women (ref. the "old boys system"). This network's aim would be to create a new system of traditions to support and enhance women's achievement of leadership positions in the health and medical care system.

3. OHRO should encourage an increase in women applicants to the health professional schools

OHRO as Catalyst

1. OHRO should review, and press legislative bodies for changes in existing laws containing sections with implicit biases against and constraints on opportunities and support for women working in health-related occupations; e.g., Medicare, Medicaid, and other health related legislation, as well as laws concerning child care, licensure of professionals, educational support, retail sales, and many others.

2. OHRO should assess new and proposed legislation concerning health and medical services and should actively promote inclusion of provisions for full utilization of woman-power at all levels of activity. Proposals for National Health Insurance should be scrutinized for implicit biases against non-physician (predominantly female) providers.

3. OHRO should, through coordination and communication with both public and private sectors of the education system, press for changes in legislation that

* Henceforth, recommendations are to be read vertically in order of priority by separate column. No recommendation was made as to the priority placed on Action/Research vs. Catalyst Categories.

(the MODVOPPP's) through demonstration projects in role model counseling, recruitment, and as promotion of career mobility for allied health practitioners.

4. OHRO should sponsor feasibility studies to explore further development of a new type of health worker, the "health ombudsman" to: a) improve health efficacy by making people better informed, more autonomous decision-makers in the determination of their own care; b) increase the potential for reducing cost escalation by promoting more efficient care; and c) improve the communication and understanding between consumers and health care providers, resulting in reduced animosities that have contributed to the malpractice problem and have also affected the cost issue.

5. OHRO should fund a demonstration model day care program for children and the elderly who are supported by single women or husband-wife dual career families, any one of whom is working in the health services field. This program should provide around-the-clock care, seven days a week and should include infants, after-school care, and provision for care during illness.

deals with education and counseling in order to assure inclusion of efforts to socialize students at all educational levels in terms of family responsibilities for child care, dual roles for both parents, non-sex-stereotyping of health careers, and the like.

4. OHRO should encourage the development of a TV series to demonstrate all aspects of women's work in health promotion and medical care. This series could serve as, and be titled, a "Show Case" of women working in science and other health and medical fields, of women serving on boards and advisory committees, and of the individuals and groups identified as allies of women working in health and medicine.

5. OHRO should encourage funding by other elements of HRA of research into determinants and effects of inequalities in earnings of men and women health workers.

C. RECOMMENDATIONS CONCERNING CONSUMERS

OHRO Action/Research

1. OHRO should immediately undertake development of a women's consumer network, utilizing fully any and all existing networks involved in women's health, to gather and disseminate information on women as consumers. The network should include specific health and health-related groups, general women's groups, and non-affiliated independent consumers. Essential to the success of this effort will be incorporation of existing networks of minority women.

2. OHRO should immediately allocate funds for development of a women's consumer council, to advise OHRO on: a) prioritizing issues; b) development of OHRO objectives; c) providing input into HRA contract review; and d) providing input into legislative development.

3. OHRO should sponsor and fund research to: a) identify existing health education services surrounding fertility-related problems; b) identify fertility-related drugs and devices which need consumer accountability; c) identify those areas of insurance regulations which deal with fertility-related services; and d) assess gaps in available information, services, and materials relating to fertility and its concomitant problems.

4. OHRO should fund development

OHRO as Catalyst

1. OHRO should continually review policy statements emanating from both public and private sector sources and should give input whenever possible, particularly concerning: a) women's prerogatives, rights, and responsibilities as health services consumers; b) demedicalization of the health and medical care system, with the aim of non-medical health support and promotion in fertility-related and other health matters; and c) economic equality for women to assure financial ability (including through insurance) to purchase high quality services.

2. OHRO should constantly assess new legislation concerning health and medical services and should actively promote inclusion of provisions for: a) facilitating women's entry into the system; b) inclusion of special provisions for women's care in health insurance laws; c) quality assessment and control in institutional licensure laws; and d) strict control of human experimentation in terms of requirements for informed consent.

3. OHRO should review existing FDA regulations, and give input to new regulations, that deal with: a) classification and use of fertility-controlling devices; b) advertising of drugs

OHRO Action/Research

of a series of alternative and/or competitive health and medical care facilities, which in addition to the necessary medical care would provide education for the use of less professionalized and technological kinds of care, at lower cost, through self-help and increased paraprofessional services.

5. OHRO should sponsor and fund research on women's self-images as users of health and medical services and their perceptions of their rights and responsibilities vis-a-vis providers of those services.

OHRO as Catalyst

and devices used by women; and c) testing of new drugs and devices.

4. OHRO should work closely with the education community and government education agencies on ways to influence and reform medical and other health professional education curricula to reflect newly developing consumer concerns and patterns.

D. RECOMMENDATIONS CONCERNING UNPAID PROVIDERS

OHRO Action/Research

1. OHRO should select and fund a series of projects designed to describe patterns of providing extra-market services. Descriptions might be in the form of a series of case histories, or collages of community experience, or comparisons between population groups, to clearly demonstrate the extent, nature, and value of provision of extra-market services.

2. OHRO should support a major demonstration project or several selective projects, which will identify alternative strategies for maximizing the use of extra-market providers' knowledge,

OHRO as Catalyst

1. OHRO should immediately devise strategies for impacting on the structure of questionnaires and survey instruments already being developed - e.g. the U.S. Census, the National Health Survey, the Bureau of Labor Statistics, the American Home Economics Association's Center for the Family, and surveys of related DHEW agencies so that information can be gathered through those instruments concerning the kinds and amounts and fair market value of health and illness services being provided on an informal, unpaid basis.

OHRO Action/Research

attitudes, and skills. This project or projects should be designed to map from actual practice the magnitude, development process, system linkages, and operational requirements that enhance the extra-market providers' contributions to the health of various population groups.

3. OHRO should immediately fund studies to determine the equivalent market value of extra-market services. Findings should be used as bases for exploring alternative strategies for reimbursement of now-unpaid providers. Legislative proposals for reimbursement should be developed based on research findings.

OHRO as Catalyst

2. OHRO should identify within the Federal government -- including DHEW regional offices -- all agencies, bureaus, offices, et al which might logically undertake study of any aspect of extra-market provision of health and illness care. These locations should be urged to build in extra-market concerns in all studies relating to health and medical services delivery. OHRO should "piggyback" on as many of these as possible for information-gathering and planning purposes.

3. OHRO should consciously and purposefully foster communication between its own staff and private sector agencies and groups having concern for and/or representing women as extra-market providers.

4. OHRO should (1) review existing health and social service legislation to see which existing programs have favorable provisions for informal providers; (2) determine the funding level and implementation status of such programs; (3) urge the Assistant Secretary for Health and relevant subagencies and offices within HEW to push for increased appropriations for these activities and proper implementation or utilization of existing authority in such programs that have not fulfilled their potential due to neglect.

5. OHRO should urge the full

OHRO Action/Research	OHRO as Catalyst
	implementation of existing federal statutes such as Medicare and Medicaid, for the purpose of enlisting maximum resource support on behalf of the extra-market provider.
	6. OHRO should urge that development and implementation of all new legislation relating to health and medical care include integration of extra-market services and their providers into planning, training, and service funding components of the legislation.

E. RECOMMENDATIONS CONCERNING DECISION-MAKERS

OHRO Action/Research	OHRO as Catalyst
1. OHRO should institute several kinds of support systems for women working in health and medicine, including at least: a) fellowships for mid-career retraining; and b) financial support for child care, travel to places of work and/or study, and other expenditures related to education and work.	1. OHRO should promote, at every opportunity, the involvement and appointment of women at the highest levels in H (of HEW).
2. OHRO should select and fund a series of educational projects to inform and train consumers and extra-market providers for participation in decision-making. These projects should use at least the resources of the media, and whatever other educational resources can be engaged.	2. OHRO should review existing health and social welfare legislation for provisions that women be accorded equal opportunity for participation in policy/decision making, and should press for actual statutory provisions mandating women's participation at decision-making levels.
3. OHRO should immediately	3. OHRO should encourage, throughout the education community, the development of experience-rating as a basis for credentialing of women health workers so that they can advance

OHRO Action/Research

undertake to identify all federal and non-federal programs relating to training and use of women in policy and decision-making, and should maintain a listing of these. This effort should also include development of a registry for women on boards and in other leadership positions, who can be brought together from time to time to share information and generate new ideas for OHRO.

4. OHRO should institute educational efforts which will contribute to the resocialization process, using: a) coloring and elementary text books for young children; b) work-study programs for adolescents; and c) family-geared educational-units for home study.

5. OHRO should select and fund research projects concerning self-selection and other modes of entry into decision-making positions. It should then expand and safeguard modes identified as effective.

OHRO as Catalyst

to decision-making levels in their chosen fields.

4. OHRO should very actively encourage and support inclusion of affirmative action requirements in all health and education legislation, with specification of levels of activity in which women must be involved.

APPENDIX I

Group I

EFFICACY OF WOMEN AS PAID PROVIDERS
A. Structure and Organization
Paper 1.

RESTRUCTURING ALLIED HEALTH EDUCATION

Eugenia S. Carpenter

Statement of Current Situation

With few exceptions, e.g., nursing, dietetics, the structure of allied health occupations education reflects the subordinate and relatively powerless roles of women as providers of health services. By virtue of the accreditation function exercised by the AMA Council on Medical Education and the ADA Council on Dental Education, control over education for a significant number of allied health occupations is dominated by the medical and dental professions.

The AMA asserts that "the accreditation of allied medical programs is a collaborative process," [1] and stresses that the sponsoring professional groups have voluntarily sought the assistance of organized medicine. Indeed, AMA involvement in accreditation of allied medical fields did arise from a request by the Occupational Therapy Association in 1933 for assistance in developing educational standards. More recently, however, there has been evidence of conflict and dissension among the groups involved. A major commissioned study of the area, SASHEP, reported that "representatives of many of the allied health professional organizations currently collaborating with the AMA maintain that the medical profession controls too much and at the same time contributes too little." [2]

Other sources of criticism of the specialized, program-by-program type of accreditation pervasive in the allied health occupations have pointed to the lack of due process and of public accountability. [3] More specific criticisms of the present structuring of allied health education as it affects career opportunities for women include:

(1) Educational credentials legitimize and freeze the existing hierarchical structure (vertical relationships) of the health care delivery system as well as the compartmentalization of the work force (horizontal relationships).

(2) Women students are socialized into submissive roles via "professional ethics" courses which stress the role of the physician as the "captain of the team" supported by subordinate health workers as team members.

(3) Narrow definitions of curricula and course content impede the development of innovative approaches to education and training.

(4) There is an inexorable trend to lengthening and "upgrading" of educational programs (from certificate to associate degree, to baccalaureate level) without any rigorous examination of the relationship between direct and opportunity costs of training and individual and social benefits of the programs (e.g., two-year programs in dental assisting were developed at a time when dental assistants were prohibited under state laws from performing any intra-oral procedures).

Existing accreditation procedures would also appear to inhibit the development of control over allied health education by public or private educational institutions. Of the 2,693 AMA-approved programs of allied health education in 1973, 72 percent were hospital-sponsored.[1] Although these programs are administered jointly by an educational institution (typically, a community college) and the clinical facility, the accrediting "approval" is to the clinical facility.

Whether a lessening of the role of physicians and dentists in determining content and setting policy for allied health education would effect significant changes in power relationships between the subordinate health occupations and medicine and dentistry is not clear. The example of nursing, which has been independent of medicine's control over accreditation and licensure from the beginning, is not encouraging in terms of fragmentation of educational programs. On the other hand, the early pattern of nursing education which subordinated training to the performance of routine services in the hospital setting of such schools has given way to the growth of academically based programs in two and four-year colleges.[4]

For many other allied health occupations, training is still tied to the service setting and includes a large number of required, unpaid, clinical hours of experience. (Until recently, x-ray technology required 2,400 clock hours of clinical service.) There is no evidence that these requirements have been analyzed rigorously to determine their justification in terms of developing minimum clinical skills needed to function safely and competently in the occupation.

Alternatives for Change

Complex, interlocking relationships link accreditation to credentialing (registration, certification and licensure) as well as to the job market (e.g., physician-dominated JCAH regulation of

hospitals). The federal government, through the Office of Education, reinforces the status quo by recognizing for funding only those educational programs which have been accredited by an approved agency.

Although this complexity resists easy analysis or simple solutions, possible strategies for change can be suggested:

(1) Alternative accrediting or approval systems could be developed, independent of the medical or dental professions, under auspices of:

(a) State educational agencies;

(b) An independent, national body of representatives of the general public as well as the various health professions interest groups and educators [2] ; or

(c) Each occupational group, following the model of nursing and dietetics.

(2) Alternative routes to credentialing (certification of competency) of allied health workers should be encouraged through more extensive development of equivalency and proficiency testing. Such efforts would require changes in state laws where licensure is involved and in standards established by professional registries in the private sector.

Justification for Change

Independent evaluation of curricula opens the possibility of exploring issues of balance between didactic and clinical training, development of core curriculum for groups of related health occupations, and content and length of programs in relation to skill levels required for job entry and to the earnings potential in the occupation.

An independent, publicly accountable system of accreditation for the allied health education programs would remove the onus of intellectual inferiority which the present system of control implicitly suggests. Under such auspices, it is also more likely that fundamental questions about the impact of accreditation policies on the number and mix of students and on the distribution and quality of practitioners produced by schools would be explored.

Vast numbers of women health workers are locked into jobs that offer little opportunity for growth. Job definitions tied to

credentials which are in turn linked to educational qualifications now present barriers to career mobility and the opportunity for women to realize their full potential as health providers.

Restructuring of the present controls over accreditation of education for the allied health professions would be one step toward introducing more flexibility into the health occupations system. Both providers and consumers of health services would be benefited.

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Group I

EFFICACY OF WOMEN AS PAID PROVIDERS
B. Financing
Paper 2.

THE IMPACT OF REIMBURSEMENT POLICIES ON WOMEN AS PROVIDERS OF HEALTH SERVICES

Eugenia S. Carpenter

Statement of Current Situation

Historically, the role of women as health providers has been perceived as an extension of their traditional sex-role; thus, the nurturing, expressive functions have been assigned to female-dominated health occupations. Nursing is, of course, the prototype of the sex-typed health occupation. Dietetics and nutrition, social work, and health education are other fields that have been so stereotyped. Where women enter a male-dominated profession, they are likely to be drawn to (or counseled into) "appropriate" areas. For example, women physicians are disproportionately clustered in such specialties as pediatrics, psychiatry, especially child psychiatry, and public health.

Analyses of the occupational structure of the health system inevitably point out the disparity in earning power between the male-dominated health professions and the vast majority of subordinate, chiefly female, health workers. What is less obvious is that the principal mechanisms for financing health care services discriminate against the preventive, supportive, and nurturing health roles which women professionals are most likely to enter.

Financing policies exert major influence in the supply and distribution of health resources, as recent studies of the impact of reimbursement policies on the geographic distribution of physicians have pointed out. The imbalance between resource development in illness-oriented, technologically complex health services and the under-investment in health promotion, including prevention, primary care, self-help and maintenance programs for the chronically ill and the aged, is consistently cited by critics of the U.S. health care system. The powerful incentive system of public and private financing of health care services will have to be redirected toward health promotion if desired changes in resource allocation in the health system are to occur.

A significant potential for expanded health services which can be provided by such professionals as nurses, nutritionists, social

workers, and health educators remains untapped because of restrictive reimbursement policies.

Proposals for Change

The thrust of the HMO movement and other efforts to promote pre-paid group practice is precisely directed to the perversities in the present fee-for-service, illness-oriented medical care system. Pre-payment experience suggests that utilization of nurse clinicians and other substitutes or complements for physicians is fostered in such settings. Nevertheless, many economists and political observers predict the persistence of the fee-for-service model as dominant financial arrangements in the health care system. It is further assumed that, while increasing numbers of women are entering medicine, and there is evidence that more women medical students are choosing "nontraditional" specialties than heretofore, the immediate future presents only incremental changes in the sex-structuring of health occupations. Therefore, women will continue to constitute the bulk of the lower-level health workers and female-typed health professions.

Given those assumptions, a change strategy directed at reimbursement policies of third-party payers whether public or private, can contribute to more effective utilization of existing resources represented by women health providers. Specific proposals include:

1. Reimbursement of physician services in noninstitutional settings should be restructured to provide positive incentives for greater task delegation to mid-level health workers (nurse clinicians, physician assistants, etc.). This would require that fees for service be based upon output measures, not input measures.

2. Coverage of the services of substitutes and complements to physician services must be provided without tying such coverage to the administrative purview of a physician's office. The services of psychologists (now covered by some programs) and psychiatric social workers, for example, would be covered under mental health services.

3. Services not now covered under conventional health insurance should be incorporated into benefit packages. These include nutritional and health education services for such classes of patients as chronic diabetics and hypertensives, maternity patients, the noninstitutionalized elderly. Unless reimbursement policies are altered to foster provision of such services, they will continue to be ill-financed and relatively unavailable.

4. Thus, suturing a wound is reimbursed at the same rate whether performed by a physician or a "mid-level health worker". (Implicit in this proposal is the possibility of developing objective standards of quality assessment.)

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Group I

EFFICACY OF WOMEN AS PAID PROVIDERS
C. Regulation
Paper 3.

LEGAL STATUS OF NURSE - MIDWIFERY IN THE U.S.

Eugenia S. Carpenter

Statement of Current Situation

The nurse-midwife is a registered nurse (R.N.) who has successfully completed one of two types of programs: (1) a course of study, usually 6-8 months in length--plus clinical experience--leading to a certificate in nurse-midwifery or (2) advanced preparation and clinical experience in a college or university program, usually 12 to 24 months in length, leading to a masters degree and to a certificate of nurse-midwifery.

In some 14 states nurse-midwives are unable to practice because of restrictive licensing laws, or restrictive interpretations of such laws. In states where there appear to be no legal impediments to the practice of midwifery, there is a wide variation in the structure of regulation. Most nurse-midwives currently practicing are found in the eastern part of the country. This pattern suggests the need to evaluate the impact of current state regulation on the climate of acceptance for nurse-midwife services.

Alternative Proposals for Change

(1) Step up present incremental change in state legislation to recognize, or legitimate, the practice of nurse-midwifery through a public education program developed jointly by HRA and such professional groups as the American College of Nurse-Midwives and the American Nurses Association.

(2) Develop a uniform statutory approach to the legislation of nurse-midwifery through a "Model Act" which might be a joint venture of an HEW Task Force and the National Commission on Uniform State Laws.

(3) Mandate in Title XIX (Medicaid Section) of the Social Security Act, a state program for licensing of nurse-midwives with uniform federal requirements. Precedent for this approach exists in the Public Law 90-248, which mandated a State program for licensing of administrators of nursing homes.

Justification for Proposed Changes

It has been proposed that the most important reason for employing nurse-midwives is that they can improve quality in the OB-GYN area. Nurse-midwives can offer expanded services for which the physician may not have time or training, particularly in the prenatal, pospartum and family planning areas. It is further argued that the nurse-midwives are better trained in the preventive, nurturing, and support services needed by maternity patients and their families. By offering a broader spectrum of services, nurse-midwives have demonstrated that care can be improved. A nurse-midwife is a health care provider whose orientation is normalcy, whose training is in the care of the normal maternity case including antepartum, intrapartum, pospartum, newborn, and family planning services. When complications occur, the nurse-midwife is trained to recognize pathologies and refer to a physician for further care. Using nurse-midwives should also reduce the cost of care by utilizing health care professionals more appropriately. For example, physician skills are underutilized in managing normal labor and delivery.

A recent study of 287 home births assisted by trained midwives in Santa Cruz, California, found a lower rate of complications than for the hospital-based births. These results were attributed to the lack of analgesia or anesthesia, preparedness of the expectant mother for childbirth and to the lack of many maternal stresses often present in a hospital birth.

Strategies for Achieving Change

Fostering a receptive legal environment and community support for the institutionalization of nurse-midwifery must take account of some negative attitudes on the part of health professionals. Both nurses and physicians have been resistant toward the use of nurse-midwives because of concerns that these new practitioners (new because they differ markedly from the "granny" or lay midwife of the past) will impinge on their roles.

The American College of Nurse-Midwifery has been ambivalent as to whether its primary allegience is to nursing or to the medical specialty of obstetrics-gynecology. The public is largely uninformed or ill-informed as to the credentials, skills, and potential contributions of these health providers.

A multi-pronged educational effort, directed to the public is probably the first step in creating a more receptive climate. This approach would be particularly appropriate if an incremental, state-by-state approach to changing the legal environment were chosen.

The more direct approach of mandating uniformity through Title XIX is more appealing from the standpoint of time for implementation and the achievement of uniformity across states. The danger of the approach is that conservative elements of the health professions (particularly medicine) could mold the legislative language into an undesirably restrictive statute.

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Group II

EFFICACY OF WOMEN AS CONSUMERS
A. Structure and Organization
Paper 4.

THE EFFECT OF THE PRESENT STRUCTURE AND ORGANIZATION OF THE HEALTH CARE DELIVERY INDUSTRY ON WOMEN AS CONSUMERS

Amber B. Jones

The structure and organization of the present health care delivery system is defined so as to facilitate the tasks of the health professional who delivers services; it is provider rather than consumer oriented. The system has been developed from the historical perspective that the role of the provider is to cure. Thus, the disease orientation of the health professions has justified the development of medical offices and centers as places where patients arrive to be treated for illness. Decision-making authority has traditionally rested with physicians who by virtue of their extensive education and training are perceived as having the most complete data on which to base diagnostic and curative decisions. In the role of expert, the physician population has moved further and further into fields of specialization; some of the functions traditionally performed by the physician are now being assumed by other health professionals. Although nurses, physicians' assistants, allied health professionals and technicians are trained to provide a variety of services, the consumer is still achieving access to the system through the physician.

Justification for Change

The disease orientation and resulting structural impediments of the present health care industry gives rise to some specific problems for women as consumers. An illustrative case is that of a young woman experiencing her first pregnancy. This person has a purpose for accessing the system: she generally believes she will want assistance with the birth process if not before. Clearly pregnancy is not an illness, and yet the present system is designed to address the expectant mother in the same manner as if she needed to be cured through treatment.

The pregnant woman is inadequately prepared to make informed choices about the quality, type, or relevant health care services available to her.

Alternative Proposals for Change

I. Short range

   A. Consumer education
   B. Utilization of and active participation in health maintenance organizations

II. Long range

   A. Revision of peer review procedures
   B. Revision of Health Manpower Legislation
   C. Development of an acceptable level of support for maternal health care needs within the proposed bill(s) for National Health Insurance.

Group Assignment: Develop Strategies for Change

The situation defined above gives rise to several issues for discussion. Some of the questions which can be addressed include: How should a person select what kind of health professional to meet which kind of a need? How can consumers adequately assess the quality of care received?

Group II

EFFICACY OF WOMEN AS CONSUMERS
B. Financing Policies and Procedures
Paper 5.

THE EFFECT OF EXISTING HEALTH CARE FINANCING MECHANISMS ON WOMEN AS CONSUMERS OF HEALTH CARE SERVICES.

Amber B. Jones

Recent surveys have indicated that the large majority of women in the work force are there because their income is required for support of themselves or required for support of themselves and of their families. Given this, health insurance becomes an important element in the financial security of employed women as well as of women who are unemployed.

Because women are disproportionately represented in lower income jobs, it is also true that the insurance benefits available to women are likely to be lower than those in more highly paid positions. However, since women are more likely to assume the major responsibility for the provision of family health needs, they are also more likely to utilize the health benefits which are available to them.

If a woman provides substantial financial support for herself and/or her family, provisions for maternity leave from the place of employment takes on an important role. Not only does there need to be adequate coverage of the costs incurred, there also needs to be some acceptable agreement as to the employment status of the woman prior to, during, and following any leave she may need.

Non-working women are also vulnerable to poor health insurance coverage. Unless the income on which this woman must live is such that it qualifies her for federally supported medical assistance, (which may or may not be fully utilized and/or understood and/or adequate) the non-working woman is totally dependent upon the person who provides the family/group income for her health insurance.

Justification for Change

Many men who are health/life insurance policy holders feel that they are providing adequate coverage for the support of their wives/dependents in the event of some unforseen circumstance. A factor seldom considered is that a widowed woman pays higher taxes

than does a married couple even though the expenditures required, particularly if there are dependents, may remain essentially the same. The increased taxes when added to the decreasing purchasing power of the dollar suggest the need for an inflation hedge if this is financially feasible.

The cheapest kind of life insurance is a group policy. Some experts feel that the amount of insurance which can be purchased under such a group coverage is inadequate. In addition, group insurance can terminate when a job ends. Thus, if a woman is relatively recently hired and some people are laid off or if a woman's husband or partner is transferred or moves and the woman chooses to move with that individual, it is not unlikely that group coverage will cease.

Alternate Proposals for Change

I. Short range

A. Consumer education:

1. Existing coverage
2. Exploration of alternatives for coverage presently available
3. Justification for selection

B. Rating of Insurance Companies as to comparative benefits for women as consumers

II. Long range

A. Development of acceptable insurance plans to meet needs commonly experienced by women:

1. Employed
2. Unemployed
3. With which kinds of dependents

B. Identification of appropriate levels of support for an acceptable level of health care of women of all ages within proposed National Health Insurance Bills.

Group Assignment: Develop Strategies for Change

The situation identified above gives rise to several issues for discussion. Some of the questions which can be addressed include: Under what circumstances is which kind of health/life insurance sufficient to adequately cover the working/non-working woman and her dependents? How can a woman evaluate advice she receives about insurance? How can National Health Insurance effect both those women who are currently insured and those who are not?

Group II

EFFICACY OF WOMEN AS CONSUMERS
C. Regulation
Paper 6.

THE EFFECT OF EXISTING HEALTH SYSTEM REGULATIONS ON WOMEN AS CONSUMERS

Amber B. Jones

Most regulations written to control the health system and the manner in which health care is delivered are presented as efforts to protect consumers. However, the intent of the regulations is not always clear and the implications of such regulations are not always carefully considered.

A common source of concern for a number of women has been the adequacy and basis for those regulations which have been developed to control contraceptive devices, in particular the intrauterine devices and the contraceptive pills.

Justification for Change

The intrauterine device (hereafter IUD) is an effective contraceptive measure; however, there are adverse side effects which can result from its use: for example, pelvic infection and perforation of the uterus, with extrusion of the IUD into the abdominal wall. Less severe but still uncomfortable side effects are not uncommon. Although the Food and Drug Administration has the regulatory responsibility for IUDs on the USA market, the use of metal IUDs was not adequately restricted until adverse side effects were reported and documented.

Unlike some contraceptive devices (condoms and chemical contraceptives) birth control pills are classified as a drug and regulated as such. Side effects of this form of contraception can be life-threatening, i.e.,formation of thrombo-embolisms. Although the pill has clearly demonstrated its effectiveness as a birth control method, the effects that its use has over a prolonged period of time, particularly when one reaches the late thirties and early forties, have yet to be substantially documented.

Regulations are frequently viewed as overly conservative constraints developed by cautious individuals. However, in each of the cases cited above, it was not until after many women had experienced negative side effects that thorough research was initiated by the responsible regulatory agency.

Alternative Proposals for Change

I. Short range

A. Consumer education

1. relevant existing literature
2. evaluation of alternatives for personal use -- who to consult?

B. Initiation of appropriate research

1. contraceptives for women
2. contraceptives for men

C. Advocacy role: abortion law

II. Long range

A. Revision of federal regulatory mechanisms
B. Legislation re: availability and use of contraceptives
C. Maintenance of longitudinal study profiles re: documentation of the effects of contraceptive methods
D. In-depth research

Group Assignment: Develop Strategies for Change

The situation identified above gives rise to several issues for discussion. Some of the questions which can be addressed include: How can women make informed judgments about the selection of contraceptives? What mechanisms can be identified to insure that existing and newly developed contraceptives are thoroughly tested and, where appropriate, regulated to insure the safety of their use?

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Group III

EFFICACY OF WOMEN AS EXTRA-MARKET PROVIDERS
A. Structure and Organization
Paper 7.

EXTRA-MARKET HEALTH AND MEDICAL CARE SERVICES FOR CHILDREN AGED 0-15

Janet A. Strauss

Current Situation

Women, as mothers and other relatives and as neighbors, domestic help, teachers, et al provide vast quantities (no one knows how much though existing time-use studies give some clues) and varying quality of health services and illness care for the 0-15 age group.

Among other services, these women provide: health promotion and maintenance via food, clothing, and shelter supervision; triage; first aid; nursing. This provision fulfills longitudinal responsibility for the 0-15 cohort and substitutes for and/or supplements market services.

All of this is expected, condoned, and encouraged -- by the system and by the larger society -- but is not acknowledged in terms of system resources and products. The system's decision makers and power structure take no responsibility for improving the non-market services nor for benefiting from input concerning them.

Methodology used, and appropriateness and acceptability of services provided, vary according to the women's (providers') socioeconomic status, education, and subcultural and religious orientations.

In addition to actually providing non-market services, women with responsibility for the 0-15 group in effect define illness and select (within system constraints) time, place, and circumstances of access to marketplace services. It might be hypothesized that women of higher socioeconomic status and having other classifiable characteristics are more efficacious in accessing the marketplace but perhaps not efficacious in improving health status -- due to overuse, iatrogenic effects, etc. of marketplace services.

Basic motivation in the provision of extra-market services is promotion and maintenance of children's health (a basic parental function), plus self-reliance for many women and cost containment for all women. However, this motivation may be negated to a large degree by anti-health role-model behavior of the mother -- i.e. smoking, overeating, alchol and other drug abuse, etc.

In terms of health and medical care career opportunities, not much of this extra-market experience is viewed as applicable, perhaps because it is simply expected, as noted above. But women who provide extra-market health and illness services for the 0-15 group amass knowledge, attitudes, and skills that could have great value in the marketplace, if ways could be found for this reality to be perceived, understood, and acted upon.

Desirable Changes

The change of choice, at both attitudinal and systemic levels, is increased awareness of the importance of health status promotion and maintenance vis-a-vis technological illness care, reflecting such awareness already held by women responsible for the 0-15 age group.

At the systemic level, efforts need to be directed to: institutionalizing health promotion and maintenance; reorienting marketplace services to be more personalized, humanistic, etc.; changing perceptions of both consumers and providers so that marketplace services reinforce the non-market ones. Formalized opportunity must be provided for input of non-market know-how into the system and into education for health and medical careers.

At the attitudinal level, efforts should be directed toward raising the consciousness of non-market (women) providers about their worth and ability to give input to the marketplace system, and of marketplace providers to view non-market providers and services as contributory and crucial.

Possible Strategies for Change

In general, methodologies must be developed to accomplish the following:

1. Perception by women extra-market providers that their knowledge, attitudes, and skills are valuable.

2. Perception, in determining marketplace decisions and policies, that extra-market providers' knowledge, attitudes, and skills are valuable and applicable.

3. Provision of input by women extra-market providers to marketplace planning, organization, and management.

4. Use both within and outside the marketplace of extra-market providers' knowledge, attitudes, and skills to influence decisions and policy at all levels, away from illness, toward health.

In addition, at the systemic level, there must be grassroots participation in civic and political matters affecting health and medical care; "infiltration" of marketplace institutions by women with non-market experience and health vs. illness orientations; cooperative marketplace and nonmarket projects analogous to the Brookline Early Education Project; and coordinated efforts to alter health professional educational objectives, content, and structure.

At the attitudinal level, there needs to be provision of role models for women extra-market providers' influencing the marketplace; disenchantment of marketplace providers with seductiveness of the technological imperative; and incorporation of attitudinal content in health professional education.

Group III

EFFICACY OF WOMEN AS EXTRA-MARKET PROVIDERS
B. Financial Policies and Practices
Paper 8.

HEALTH AND MEDICAL CARE SERVICES PROVIDED BY VOLUNTEERS

Janet A. Strauss

Current Situation

Women, working as unpaid volunteers in health and medical care (chiefly medical care) institutions, agencies, and programs provide substantial amounts of paramedical, allied health, and support services.

They probably provide more services related to illness care than to health promotion and maintenance, and probably contribute more to improving acceptability than to enhancing accessibility and appropriateness. When they provide services similar to and directly supplemental to those of paid marketplace providers, under more or less direct supervision of those providers, they reinforce marketplace practices.

Questions which may or may not be answered by currently available data include the following: Do volunteers supplying these services on a "free" basis make marketplace illness care less expensive? Or do they make it more expensive in terms of paid providers' including charges for these "free" services as part of their own charges? Does Blue Cross count in the worth of volunteer services in hospitals? If women now providing volunteer services were to seek paid careers, how would this affect the economics of health and medical care? What potential is there for decision-making and policy input to the health and medical care system by volunteers? Since volunteer women are in many cases also extra-market providers for children 0-15 and/or aged parents or other relatives (cf. papers 7 and 9), how does this influence their perceptions of the volunteer role?

Desirable Changes

At the systemic level, methodology should be developed for reflecting volunteer input in cost structures, or conversely, doing away with "free" services and paying individuals to perform them, thus releasing some volunteers for activities ranging up to policy and decision-making.

If women are freed from supporting policies and practices of the male-dominated health and medical care system, they may work toward emphasizing health promotion and maintenance, drawing on their other extra-market experience and motivations.

At the attitudinal level, motivation for assuming other roles (non-volunteer) and seeking education for paid careers may be developed.

Strategies for Change

See Paper 7 for four general strategies. In addition, at the systemic level, methodologies should be found for reducing kinds and quantities of volunteer services acceptable and allowable in institutions, agencies, and programs. At the attitudinal level, elements of relevance should be introduced into secondary, post-secondary, and higher levels of education for women.

Group III

EFFICACY OF WOMEN AS EXTRA-MARKET PROVIDERS
C. Regulation
Paper 9.

EXTRA-MARKET LONG TERM HEALTH AND MEDICAL CARE SERVICES FOR THE AGED

Janet A. Strauss

Current Situation

Women, as daughters and other relatives, and as neighbors, domestic help, et al provide large quantities(no one knows how much) and varying quality of health and illness care for the over-65 age group. Among other services, these women provide assistance with food, clothing, shelter; assistance with activities of daily living; transportation; first aid; triage; and nursing. This all substitutes for and/or supplements market services -- but is not accorded recognition nor viewed as competitive with market services.

The provision of services is expected, condoned, and encouraged -- by the system and by the larger society -- but is not regulated as such.

However, societal provision for health and medical care for the aged is hedged about by innumerable regulations -- now most notably through Medicare -- which concentrate on illness care but do not assure access to appropriate and acceptable services.

Families, particularly women, bear heavy responsibility for providing both health maintenance and illness care for this age group and/or arranging for facility care. When care is provided at home, it is apt to be burdensome in economic, social, and psychological terms. When the aged are "sent away" from their own or their children's homes, high costs in terms of money and guilt are almost as difficult to bear.

Ineffectual regulation of long-term care facilities adds to problems of those (women) responsible for placement of the aged.

Lack of regulation of providers' decision-making condones their decisions to avoid and neglect uninteresting geriatric patients, leaving the burden of decision-making, home-remedying, etc. with the women extra-market providers.

Motivations for providing non-market health and medical care services tend to be mixed, ambivalent -- more so than with children 0-15. Cost containment is often more important than health maintenance though these are closely related. Motivations are similar at different socioeconomic levels. Frustrations related to compliance with social security, public assistance et al regulations are apt to be "taken out" on the aged, adding to their woes and problems.

Desirable Changes

At the systemic level, avoidance of increasing numbers of dependent chronically ill aged is most desirable. Also, maintenance of the usefulness (working capacity) of over-65 individuals will be important to the economy as population age ratios shift. This is an area where change will need to be more specifically mandated than for 0-15, because of different motivations for provision of non-market services. As the ratio of aged/working population increases, regulation of the long-term care sector of the health and medical care system will need to concentrate more on health promotion and maintenance and on finding acceptable alternatives to care by relatives.

At the attitudinal level, the importance of health-oriented self-images and societal images of over-65 individuals is increasing. More societal acceptance, concern, humanistic interest, and support will need to be developed. A health-oriented over-65 population is greatly to be desired and regulations should encourage this rather than discouraging it by continued concentration on illness care. Self-care and independence will become crucial. Women will need particular education in this area since their life expectancy is still greater than men's.

Strategies for Change

See Paper 7 for four general strategies. In addition, at the systemic level, cost-efficiency pressures can initiate development of regulations that will emphasize health promotion and maintenance, stress importance of self-care and provide for subsidization of self-care and various alternatives, so that women relatives can be relieved of the burdens of providing non-market services, without concomitant guilt burdens.

At the attitudinal level, regulations can stress continuing education at the community group level for older persons' health maintenance and can reorient profit-motivated marketplace providers of illness care to provide more health-positive sorts of services.

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Group IV

EFFICACY OF WOMEN AS DECISION MAKERS
A. Structure and Organization
Paper 10.

ORGANIZATIONAL CONSTRAINTS UPON WOMEN MANAGERS IN THE HEALTH SYSTEM

Elizabeth C. Bellis

I. The Present Situation

Starting from the premise that the quality of health services will be improved by increasing the numbers of women in policy-making positions, this paper presents an overview of how the patterned expectations of others, as expressed in informal organizational policies and practices, and the formal structure of health organizations operate as constraints upon women who want to become managers in the organized health system. The woman decision maker brings her own personal history into dynamic interplay with these organizational constraints, with the result that more or less difficulty for her career develops at critical phases that may be labelled "moving in," "moving up," and "moving on."

Moving In

Entry into the management field involves issues of access, assessment, and contract. Usually lacking a referral network, the woman applicant first has to break into the Old Boy system working through conscious and unconscious assumptions made by men about career patterns of women, geographic mobility, and competencies. The same issues must be addressed during the initial interviewing process. In assessing the job potential, the woman applicant does not have an informal information network as men often do. She has to evaluate the organization's practices and policies about women in management and discern skills that are encouraged or discouraged inappropriately in women. When the job offer is made, the problem becomes how to negotiate trade-offs that the woman applicant needs without jeopardizing advancement or promoting stereotyping.

Moving Up

To move up in the organization, a would-be manager has to 1) develop specific and organizational skills, 2) wins allies, and 3) acquire authority over people and strategic turf -- but there are more constraints upon women than men in all of these areas.

1. Formal and informal organization practices encourage women's orientation and assignment to circumscribed task accomplishment. But the more generalized managerial skill of making decisions, and thus policy, is learned in the context of a job that mirrors organization dynamics. Learning this aspect of management is made difficult not only by the specificity of the job but also by the closed fellowship of men in their shop-talk and gathering places. Conversely, informal practice may hinder the development of specific key managerial skills that are associated with the masculine role (operations research, financial management, environmental controls) or connected with organizational "credentials" that women less often acquire than men (some clinical degrees, MBA's and PhD's).

Certain management skills are learned through "failure" as well as success, yet organizations (and many women themselves) tend to view failure by women as career-predictive rather than as a learning experience. This becomes a stereotype used in negotiations around other women. Calculated risk-taking is also important to strong and creative management, but risk-taking for a woman is especially chancey in view of this attitude toward failure.

2. A common way to move up the ladder is to win the backing of allies in higher positions and the allegiance of those one supervises, yet men in either position do not see their power or prestige enhanced by supporting a woman. Women as allies in either position are not attended to by the organization in the same way that men are. Similarly, women are unlikely to become managers in situations where subordinates will be chiefly men. Furthermore, if a woman manager (clinician or non-clinician) has the responsibility for the operations of a clinical program, she will find that male clinicians usually outrank her in terms of salary and status. It is no surprise that a competent woman may end up managing programs on organizational boundaries, a vulnerable and out-of-the-mainstream position. Here she may find herself with great responsibility, few resources, and little organizational prestige.

Moving On

On-the-job success for a woman does not necessarily mean advancement to another managerial post outside or inside the organization because she must prove herself over and over. Her present success may be regarded as unique, fortuitous, sponsored, easy, or the results of being an "aggressive" woman. Many organizations make further assumptions -- that they look better to others if they have male managers, that women, in any event, don't want to move, won't give up a "safe" job. Finally, organizations act out the myth that the good male executive will move on, but that the "good" woman will stay put.

II. Strategies for Change

Change strategies involve:

1) basic education, at all levels,

2) applying pressure upon organizations to increase real management opportunities for women (negative and positive sanctions),

3) increasing women's management skills by special extra-organizational means (support and referral networks, training workshops, and management internships, among others).

Group IV

EFFICACY OF WOMEN AS DECISION MAKERS
B. Financing Policies and Practices
Paper 11.

FINANCING CONSTRAINTS UPON WOMEN AS MANAGERS IN THE MENTAL HEALTH SYSTEM

Elizabeth C. Bellis

I. The Present Situation

Financing policies and practices of the mental health system make it difficult for women to become or be effective managers of programs and services in that system.

A. Federally-funded health training programs discriminate -- in practice -- against the career development of women graduate students, allied health trainees, and faculty women. In schools of public health, for instance, which for years were the chief loci for training in community mental health programs, training awards went to those who already possessed an advanced degree in clinical work. Women were least likley to have these degrees, or holding them, to search out another degree at the same Master's level. If they entered the program, they were funded at lower levels than the psychiatrist, usually male, who was enrolled in the same program. In psychology and sociology, fields that might feed into the mental health system graduate, women students were similarly disadvantaged. The allied health professional field has appealed particularly to working class and often minority women, but their financial needs have been woefully under-estimated in training grants and many never finish the program because of inadequate funding. If they do, most find their careers blocked unless they obtain a baccalaureate, again a financial burden on the woman and one that is not supported financially by the system that recruited her to the supposedly "new career." The disadvantaged faculty position of women is well known. Because they are underrepresented on grant review committees, women do not often have the chance to challenge or change policy on funding projects requested by women.

B. When women do arrive in managerial positions in the mental health system, financing practices and policies continue to work against them. Salaries are lower for women, even for physicians, than for men. For non-clinical women managers, educational credentials may be more important to the institution then experience; yet women are less apt to have had the financial help that makes these credentials possible.

Less obvious is the impact on women of financing policies involving certain mental health programs. Women managers are over-represented in the so-called "community" services -- support systems, human services, and out-reach programs -- and tend to stay in these services, unlike men who are there on a transitory basis. Because these programs consist of indirect services, recipients of service are difficult to identify and they are not accurately counted in the patient care statistics submitted to funding agencies. Thus, the work of these services does not show up in true perspective. As a result, both the woman manager and the program she runs are also undervalued.

Mental health education, the one program in which women actually outnumber men, is often not carried out by community mental health centers, despite the fact that consultation and education is one of the "essential" functions in the original legislation and the most recent amendments. In addition to tolerating financing policies that can by-pass a mandated program, the centers tend to fund those positions that do exist at a lower level of pay and define the job with less responsibility than the mandate would appear to specify.

II. Strategies for Change

1. Training grant policy should be reviewed to see that adequate stipends are available, particularly to women with children, and that all proposed allied health professional programs prepare their graduates to meet the state's job specifications for promotions.

2. Programmatic services in community health centers should be represented in financing policies in some proportionate way to the clinical services.

3. An oversight committee, located in OHRO or a woman's institute, should be charged with reviewing policy and implementation in programs that affect women's training, jobs, and services to women.

Group IV

EFFICACY OF WOMEN AS DECISION MAKERS
C. Regulations
Paper 12.

DECISION-MAKING ABOUT MEDICAL TREATMENT

Elizabeth C. Bellis

The Present Situation

Self-care advocates, many in the women's movement, and some professionals in the health care system call for more decision-making by women about their medical care. Women are asked to know their own bodies, to recognize and make known their needs and feelings about both treatment and providers, and to bring their influence to bear on changing the present system, which is thought at best to be paternalistic, at worst antagonistic to the participation of patients in their own care. This paper examines the role regulations play in allowing women to make decisions about acute care, using as examples breast cancer and hysterectomy. In the first, there are now indications that treatment is changing and options exist. Decisions must be made at many points. In the second, well-documented studies show that of all major surgical interventions, hysterectomy is the operation most often unnecessarily performed.

At first glance it would appear that the regulations that now exist protect women's rights to make decisions about their treatment. Regulations give patients the right to consultation, the right to refuse recommended treatment, and the right to define in the consent form what surgical procedures will not be allowed by the patient. Yet there may be a Catch-22 in all of this, for nothing protects the patient against a decision by her physician to discontinue her as a patient.

To say that the patient has chosen and knows her physician and that such an event is unlikely begs the question, for the primary physician is not usually the doctor with whom the patient is now dealing nor should we even assume that most patients have primary physicians. The patient is usually conferring with a stranger when she arrives for specialized care, or even a series of strangers in the case of breast cancer.

The more stable element in this situation is that physicians are trained and function in a peer group society -- and are regulated and reviewed by peers.

The patient may be disadvantaged in finding another physician, if she disagrees with or questions the first. She may find it difficult to find out anything about the surgeon to whom she is referred since this is a closed society, difficult to find out how she is perceived (labelled), and difficult to find out what information exists about indications for treatment and specific types of treatment that may be available. Essentially, though the patient has the right to ask, and to see her own medical record, the regulations carry less weight than one would think. The patient is caught up in a system that professionalizes itself in such a way that patient participation or decision-making is a totally alien concept. Women seem to be doubly disadvantaged in that they must now face the male as well as physician stereotyping of women and patients. The medical system, by emphasizing acute care, increases the probability that the patient will arrive for treatment already ill, uninformed, and unlikely to challenge treatment dicta.

II. Strategies for Change

Strategies involve 1) strengthening the rights of consumers, in general, and of women consumers, in particular, in decision making and 2) producing in the system receptivity to this idea as well as accountability procedures.

1. In the first group, we might think of health curricula at early and all ages that promote familiarity with, awareness of, and responsibility for one's own body, some base-level competencies, and a demythification of medical care.

2. For the system, more caring and less stereotyped attitudes toward women and a better understanding of consumer rights may perhaps occur as more women enter the medical profession. The process of accepting women into medical schools and other professional health schools should be monitored, publicized, and cleansed of the notion of acceptable levels. Patient advocates should be available to all patients and a civilian presence should be mandated on hospital tissue committees, hospital Boards, and review and regulation committees.

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Appendix III

"Double Dynamics: Women's Roles in Health and Illness"

Participants

Marjorie Bear-Don't-Walk
4507 Porcupine Drive
Helena, Montana 59601
(406-442-4852)

Elizabeth C. Bellis, M.P.H., M.U.S.
Assistant Dean
Public Health Curriculum
School of Medicine
Yale University
60 College Street
New Haven, Connecticut 06510
(203-436-8464)

Janet Welsh Brown, Ph.D.
Head, Office of Opportunities in Science
American Association for the Advancement of Science
1776 Massachusetts Avenue, N.W.
Washington, D.C. 20012
(202-467-4496)

Rita Ricardo Campbell, Ph.D.
Senior Fellow
The Hoover Institution
Stanford University
Stanford, CA 94305
(415-497-2074)

Eugenia Carpenter, M.P.P.
Assistant Research Scientist
Department of Health Planning and Administration
School of Public Health
University of Michigan
Ann Arbor, Michigan 48104
(313-764-2132)

Barbara Cleaveland, M.S.W.
Assistant Professor
School of Social Work
University of North Carolina
Chapel Hill, NC 27514
(919-933-1226)

Verna Cook, Ph.D.
Research & Evaluation Branch
Office of Health Resources Opportunity
Department of Health, Education and Welfare
Room 10-35 Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852
(301-443-2154)

Catherine Cowell, Director
Bureau of Nutrition
New York City Department of Health
93 Worth Street, Room 714
New York, NY 10013
(212-566-6026)

Arlene Kaplan Daniels, Ph.D.
Director, Program on Women
Northwestern University
619 Emerson Street
Evanston, Illinois 60201
(312-492-7360)

Barbara Ehrenreich, Ph.D.
16 Walter Avenue
Syosset, New York 11791
(516-364-9676)

Leon Eisenberg, M.D.
Maude and Lillian Presley
Professor of Psychiatry
Department of Psychiatry
Children's Hospital Medical
Center
300 Longwood Avenue
Boston, Massachusetts 02115
(617-734-6000 ext.2545)

William S. Flash, Ph.D.
Associate Professor
School of Public Health
University of North Carolina
Chapel Hill, North Carolina
27514
(919-966-5191)

Lucy Ann Geiselman, Ph.D.
Assistant Vice Chancellor
University of California at
San Francisco
San Francisco, California
94143
(415-666-4007)

Jeannette V. Haase, Ph.D.
Director, Programs in Health
Care
Radcliffe Institute
77 Brattle Street
Cambridge, Massachusetts
02138
(617-495-8216)

Gladys Handy, M.A.
Deputy Commissioner for Higher
Education
Department of Education
Box 911
Harrisburg, Pennsylvania
17126
(717-787-7572)

Martha Harris
Special Assistant
U.S. Office of Education
Room 5106
Regional Office Building 3
7th and D Street, S.W.
Washington, D.C. 20202
(202-245-2648)

Marilyn Heins, M.D.
Associate Dean for Student
Affairs
School of Medicine
Wayne State University
1261 Scott Hall
540 E. Canfield
Detroit, Michigan 48201
(313-577-1463)

Amber B. Jones, M.Ed.
Assistant Program Coordinator
Association of American
Medical Colleges
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036
(202-466-4692)

Elaine Menter Katzman, R.N., M.S.
NOW Task Force in Women's Health
Assistant Professor
College of Nursing
University of Florida
Box 768
Gainesville, Florida 32601
(904-393-3515)

Karen Keesling, M.S.
Director
Office of Women's Programs
The White House
Old Executive Office Building
Room 196
Washington, D.C. 20500
(202-456-2663)

William L. Kissick, M.D., Dr.P.H.
George S. Pepper Professor of
Community Medicine
Department of Community Medicine
University of Pennsylvania
36th & Hamilton Walk/GA
Philadelphia, Pennsylvania 19174
(215-243-6385)

Margaret Kohn, J.D.
Attorney
Women's Rights Project of the
Center for Law and Social Policy
1751 N Street, N.W.
Washington, D.C. 20036
(202-872-0670)

Daniel H. Kruger, Ph.D.
Professor of Industrial Relations
School of Labor and Industrial
Relations
728 S. Kedzie Hall
Michigan State University
East Lansing, Michigan 48824
(517-353-7231)

Dorothea C. Leighton, M.D.
Retired Professor of Mental Health
2614 Warring Street
Berkeley, California 94704
(415-848-3135)

Sonia Leon
Acting Chief, Program Coordination
Branch
OHRO, Department of Health,
Education and Welfare
Room 10-35, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852
(301-443-2154)

Mary Ann Lewis, R.N., M.S.
Project Director and Family
Nurse Practitioner
Primex Project
University of California,
Los Angeles
221 Burlingame Avenue
Los Angeles, California 90049
(213-825-7213)

Jean Lipman-Blumen, Ph.D.
Director, Women's Research Program
National Institute of Education
Department of Health, Education
and Welfare
1200 19th Street, N.W., Room 815
Washington, D.C. 20208
(202-254-5406)

Leslie L. Luttgens
2505 Green Street
San Francisco, California 94123
(415-921-8838)

Rolf P. Lynton, Ph.D.
Dean, School of Public Health
William-Brice College of
Nursing Building
University of South Carolina
Columbia, South Carolina 29208
(803-777-2301)

Maggie Matthews, Dr.P.H.
Assistant Director for Special
Programs
Office of Health Resources
Opportunity
Health Resources Administration
Room 10-35 Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852
(301-443-2154 or 1516)

Pauline Miles, M.S.W.
Assistant Vice President for
Program
National Health Council
1740 Broadway
New York, New York 10019
(212-582-6040)

Frank Moore, Ph.D.
Associate Dean
Tulane University
150 S. Liberty Street
New Orleans, Louisiana 70112
(504-588-5397)

Charlotte Muller, Ph.D.
Associate Director
Center for Social Research
City University of New York
33 W. 42nd Street, Room 1201
New York, New York 10036
(212-790-4207)

Francie Petrocelli
Program Coordinator
Health Policy Program
School of Medicine
University of California
San Francisco, California 94143
(415-666-4921)

Elinor N. Polansky, M.S.W.
Assistant Professor
School of Social Welfare
Health Sciences Center
State University of New York
at Stony Brook
Stony Brook, Long Island
New York 11790
(516-444-2153)

Sheryl K. Ruzek, M.A.
Visiting Lecturer
Department of Social and
Behavioral Sciences
School of Nursing
University of California,
San Francisco
1373 Third Avenue
San Francisco, California
94143
(415-666-3047)

Ellen Sax
Research & Information
Coordinator
Manpower Distribution Project
National Health Council
1740 Broadway
New York, New York 10019
(212-582-6040)

John Scanzoni, Ph.D.
Professor
Department of Sociology
Ballantine Hall
Indiana University
Bloomington, Indiana 47401
(812-337-3329)

June Schneider
Program Assistant
Center for Women in Medicine
The Medical College of
Pennsylvania
3300 Henry Avenue
Philadelphia, Pennsylvania
19129
(215-842-7108)

Eva L. Scott, M.S.W.
Special Assistant to the
National Executive Director
Girl Scouts of the U.S.A.
830 Third Avenue
New York, NY 10022
(212-751-6900 ext 206)

Clay Simpson, Ph.D.
Associate Administrator for
Health Resources Opportunity
Programs
Health Resources Administration
Department of Health, Education
and Welfare
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852

Jane Sprague, Ph.D.
Chairperson, Women's Caucus,
APHA
Assistant Professor
Department of Community
Medicine-Health Policy
Division
Muir c-007
University of California,
San Diego
La Jolla, California 92093
(714-452-2895)

Janet A. Strauss, M.P.H.
Executive Director
Council on Education for Public Health
1015 18th Street, N.W.
Washington, D.C. 20036
(202-467-5061)

Theodis Thompson, Ph.D.
Chairman
Health Services Administration Department
Howard University
2345 Sherman Avenue, N.W.
Washington, D.C.
(202-636-7448)

Ira D. Trail, R.N., Dr.P.H.
Director
Division of Nursing
University of Massachusetts
Amherst, Massachusetts 01002
(413-545-2544)

Mary Ellen Verheyden-Hilliard, Ph.D.
Director
Sex Equality in Guidance Opportunities Project
American Personnel and Guidance Association
1607 New Hampshire Avenue, N.W.
Washington, D.C. 20009
(202-483-4633)

Patricia Von Bargen
Program Development Specialist
Office of Health Resources Opportunity
Health Resources Administration
Parklawn Building, Room 1134
5600 Fishers Lane
Rockville, Maryland 20852

Daniel F. Whiteside, D.D.S., M.P.H.
Director
Bureau of Health Manpower
Health Resources Administration
Department of Health, Education and Welfare
Room 5c-20, NIH Building
9000 Rockville Pike
Bethesda, Maryland 20014
(301-496-2068)

Nina B. Woodside, M.D., M.P.H.
Director
Center for Women in Medicine
The Medical College of Pennsylvania
3300 Henry Avenue
Philadelphia, Pennsylvania 19129
(215-842-7108)

Kinzo Yamamoto, Ph.D.
Chief, Utilization & Expenditure Statistics Branch, DHIS
DHEW/PHS/HRA/NCHS/Division of Health Interview Statistics
5600 Fishers Lane, Room 9-36
Rockville, Maryland 20852
(301-443-4043)

Sylvester H. N. Zumbrun
Deputy Coordinator
Metropolitan Washington Regional Medical Program
Medical Society of the District of Columbia
2007 Eye Street, N.W.
Washington, D.C. 20006
(202-223-8050)

WORK GROUPS

Group I: The Efficacy of Women as Paid Providers

Meeting Room - Suite 208

Facilitator: Eugenia Carpenter
Recorder: Ira Trail

- Marjorie Bear-Don't-Walk
- Rita Ricardo Campbell
- Barbara Ehrenreich
- Lucy Ann Geiselman
- Marilyn Heins
- Daniel Kruger
- Ellen Sax
- Mary Ellen Verheyden-Hilliard
- Daniel F. Whiteside

Group II: The Efficacy of Women as Consumers

Meeting Room - Suite 308

Facilitator: Amber Jones
Recorder: Pauline Miles

- Verna Cook
- Arlene Kaplan Daniels
- William S. Flash
- Elaine Katzman
- Charlotte Muller
- Sheryl Ruzek
- John H. Scanzoni
- Theodis Thompson

Group III: The Efficacy of Women as Extra Market Providers

Meeting Room - Suite 408

Facilitator: Janet Strauss
Recorder: Martha Harris

- Barbara Cleaveland
- Catherine Cowell
- Gladys Handy
- Margaret Kohn
- Dorothea Leighton
- Leslie Luttgens
- Rolf Lynton
- Frank Moore
- Elinor Polansky
- Kinzo Yamamoto

Group IV: The Efficacy of Women as Decision Makers

Meeting Room - Suite 508

Facilitator: Elizabeth Bellis
Recorder: Jeannette Haase

- Janet Brown
- Leon Eisenberg
- Karen Keesling
- William Kissick
- Sonia Leon
- Mary Ann Lewis
- Jean Lipman-Blumen
- Francie Petrocelli
- Eva Scott
- Jane Sprague
- Sylvester Zumbrun

CONFERENCE EVALUATION

Those present were asked to evaluate the conference against the stated objectives by completing a brief form asking for a ranking of the format, participants, resource materials, mini-papers, conference facilities and output of group sessions. Forty-three out of fifty participants responded. The evaluations were predominantly favorable.

	Very Good	Satis-factory	Unsatis-factory	Comments
Program Format	26	15	2	9
Participants	28	13	2	13
Resource Materials	28	13	2	9
Mini-papers*	19	18	4	7
Conference Facilities	20	21	2	10
Output of Group Sessions	22	18	3	7
Other Comments	-	-	-	19

* 1 not used
1 mixed

n = 43

There were several questions raised regarding the structure of the workshop which some participants felt was constricting and overly-complicated. One participant felt that the format was excellent but that the group strayed from the assigned topics too much. Another participant felt that "either greater structure or stronger direction from the facilitator was needed."

Comments on the evaluation forms and letters from participants which arrived following the conference indicated that people generally felt that the conference had been very successful in generating recommendations to assist OHRO in developing a long-range plan.

In addition to the recommendations generated at the conference for long-range planning, a number of letters were received reporting immediate outcomes which were spin-offs from the conference. A few examples are the inception of a network among conference participants with common goals; efforts to encourage the idea of child care centers for mothers working in health care institutions; propagation of ideas in the area of career mobility; initiation of a study of women providing extra market services; perspectives of the initial development of a Women's program in an academic health institution.

Ultimate evaluation of this Conference will be, of course, the research projects and action programs which resulted from recommendations generated at the conference plus a number of serendipitous outcomes resulting from the interaction of the participants at the conference.

It is anticipated that a follow up will be carried out within the year to get feedback from participants on what effects the conference had on their programs and to inform them of what progress has been made at OHRO by that time.

Appendix VI

List of Reviewers

The conference summary and recommendations in first draft were reviewed by the following individuals and groups:

Director, OHRO

Deputy Director, OHRO

Chief, Research & Evaluation Branch, OHRO

Chief, Program Development Branch, OHRO

Chief, Program Coordination Branch, OHRO

Program Development Specialist, Program Development Branch, OHRO

Program Analyst, Program Coordination Branch, OHRO

Program Development Specialist, Research & Evaluation Branch, OHRO

Members, HRA Council for Women and Health

DHEW/PHS Regional Coordinators for the HRA Women's Program

Program Chai., National Medical Association Auxiliary

Coordinator, HRA Federal Women's Program

Director, HEW Women's Action Program

Director, White House Office of Women's Programs

Chair, Women's Caucus, American Public Health Association

Chief, International Programs Branch, Division of Medicine

We wish to thank them for their comments and suggestions.